STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100450580A	A. BUILDING B. WING	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHMASTERS INC	3200 WILLOWCREEK ROAD SUITE B, PORTAGE, IN, 46368

(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
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: 5/31 (survey entrance was attempted, but agency was unstaffed/locked, and the surveyor was unable to reach agency staff by phone due to "voicemail full"); and 6/6, 6/7, 6/8, 6/9, 6/10, 6/13, and 6/17 (2022). The survey exit date was extended due to the receipt of pertinent documents requested during the on-site survey, but not received until 6/17/2022. The agency was notified of this possibility during the exit conference on 6/13/2022 at 4:10 PM. Census: 7 Healthmasters Inc. was found to be not in compliance with 410 IAC 17 in regard to a State Re-licensure survey. Quality Review completed on 7/13/22 by SFF	N0000		2022-10-07

G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure Survey of a Home Health provider. Survey Dates: 5/31 (survey entrance was attempted, but agency was unstaffed/locked, and the surveyor was unable to reach agency staff by phone due to "voicemail full"); and 6/6, 6/7, 6/8, 6/9, 6/10, 6/13, and 6/17 (2022). The survey exit date was extended due to the receipt of pertinent documents requested during the on-site survey, but not received until 6/17/2022. The agency was notified of this possibility during the exit conference on 6/13/2022 at 4:10 PM. Census: 7 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. See State Form for additional findings. During this Federal Recertification Survey, Healthmasters Inc. was found to be out of compliance with Conditions of Participation 42 CFR §484.55: Comprehensive Assessment of Patients; 42 CFR §484.58: Discharge Planning; 42 CFR §484.60: Care Planning, Coordination of Services, and Quality of Care; 42 CFR §484.65: Quality Assessment and Performance Improvement (QAPI); 42 CFR §484.70: Infection Prevention and Control; 42 CFR §484.80: Home Health Aide Services; 42 CFR §484.105: Organization and Administration of Services; and 42 CFR §484.110: Clinical Records. Based on the Condition-level deficiencies during the 6/13/2022 survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 6/09/2022. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training, skills competency and/or competency	G0000		2022-10-07

	beginning 6/13/2022 and continuing through 6/12/2024. Quality Reveiw Completed on 07/13/2022 by SFF			
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR §484.102 for a Home Health Provider and Suppliers. Survey Dates: 5/31 (survey entrance was attempted, but agency was unstaffed/locked, and surveyor was unable to reach agency staff by phone due to "voicemail full"); and 6/6, 6/7, 6/8, 6/9, 6/10, and 6/13 (2022). Census: 7 At this Emergency Preparedness survey, Healthmasters Inc. was found to be out of compliance with Conditions of Participation 42 CFR §484.102: Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, including staffing and the implementation of staffing during a pandemic. Quality Review Completed on 07/13/2022 by SFF	E0000	Healthmasters will utilize its updated emergency preparedness management policy. the updated policy will cover the following: 1) emergency plans 2) policies and procedures 3) communication plan 4) training and testing. Utilizing this policy will insure that management and staff will will be available and able to receive all phone calls during office hours and on-call after business hours. Healthmasters will contract with Medical Exchange Answering service Inc. the service will monitor our phone services whenever our normal phone services are off line. This phone service will be monitored by the Assistant Administrator, and will be ongoing. Services will be in place and running by Aug 12,2022.	2022-10-07
E0001	Establishment of the Emergency Program (EP) 403.748,482.15,485.625 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68,	E0001	Healthmasters hasupdated its policies and guidelines toinclude a Emergency Preparedness Management Policy, which includes a covid 19pandemic policy. This will be	2022-08-31

	§485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: Based on record review and interview, the home health agency failed to maintain an emergency preparedness plan that was		reviewed and/or updated at lease every two(2)years. All staff will be oriented to the emergency management plan and theirassociated responsibilities. Reviews will be held at least annually. Healthmasterswill conduct an analysis to identify potential emergencies (identified for ourarea) , and the effects these emergencies could have on our client services.Purpose: 1) Establish guidelines for client care during anemergency or disaster. 2) Provide direction/instructions for staff tofollow during life-threatening situations, which could disrupt home careservices. 3) Develop disaster readiness and emergencymanagement. 4) Identify healthmasters relationship to a community wide EMP. Situations which can constitute an emergency , include ,butnot limited to:	

	(see tag E0004); ensured the plan included a current facility-based or community-based risk assessment, to include the COVID-19 pandemic; or strategies for addressing emergency events identified by the risk assessment (see tag E0006); maintained current policies and procedures, with review and update(s) at least every 2 years (see tag E0013); developed a procedure to follow up with on-duty staff and patients to determine services that were needed, in the event that there was an interruption in services during or due to an emergency (see tag E0021); developed and maintained an emergency preparedness communication plan which included the use of volunteers or other emergency staffing in the event of an emergency to ensure the healthcare needs of the patients were met (see tag E0024); developed and maintained an emergency preparedness communication plan which included names and contact information for other entities providing services under arrangement (E0030); developed and maintained an emergency preparedness communication plan which included primary and alternate means for communicating with agency staff (E0032); developed and maintained an emergency preparedness training and testing program, that must be reviewed and/or updated at least every 2 years (see tag E0036); ensured emergency preparedness training was provided at least every 2 years, or more often as needed, or maintained documentation of all emergency preparedness training (see tag E0037); or conducted exercises to test the emergency plan annually (E0039). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment and resulted in the agency being found out of compliance with the condition 42 CFR §484.102: Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, including staffing and the implementation of staffing during a pandemic.		A) Floods,tornadoes,hurricanes,blizzards, andstorms. B) Natural disasters C) Communications systems/utilities failure due tooutage of telephone/electricity. D) Security incidents, bomb threats, or civildistubances. E) Staff shortage In the event Healthmasters telephone or utility service are interrupted: a) Staff will contact the repair company informing them ofthe nature of our services,requesting priority rating for restoring service. b) Telephone call will be forwared to our answeringservice or alternate number if possible. c) Staff will utilize pagers, mobile telephones, orpersonal telephones to contact clients, and arrange to provide needed services. d) If utilities are interrupted,	

			calls to the answering service, and follow procedures establishedfor on-call hours. In the event of damage to the office, the administrator willmake arrangements for an alternate location. Operations will continue from thealternate site. Secure transfer of client /and or personnel records(if needed). Links to local community organization that may be needed toassist Healthmasters in assisting our clients needs or may need help to respondto community needs. Administrator will monitor this policy, policy on-going	
E0004	Develop EP Plan, Review and Update Annually 403.748(a),482.15(a),485.625(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).	E0004	Healthmasters hasupdated its policies and guidelines toinclude a Emergency Preparedness Management Policy, which includes a covid 19pandemic policy. This will be reviewed and/or updated at lease every two(2)years. All staff will be oriented to the emergency management plan	2022-09-01

	The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (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 all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . Based on record review and interview, the home health agency failed to maintain an emergency preparedness plan that was reviewed and/or updated at least every 2 years.		and theirassociated responsibilities. Reviews will be held at least annually. Healthmasterswill conduct an analysis to identify potential emergencies (identified for ourarea) , and the effects these emergencies could have on our client services.Purpose: 1) Establish guidelines for client care during anemergency or disaster. 2) Provide direction/instructions for staff tofollow during life-threatening situations, which could disrupt home careservices. 3) Develop disaster readiness and emergencymanagement. 4) Identify healthmasters relationship to a community wide EMP. Situations which can constitute an emergency , include ,butnot limited to: A) Floods,tornadoes,hurricanes,blizzards, andstorms. B) Natural disasters C) Communications systems/utilities failure due	

	Findings include: An undated agency policy received on 6/09/2022 titled "Disaster/Emergency Preparedness" indicated the agency would review the emergency plan annually, must make a good faith effort to comply with the plan during a disaster, and if unable to comply, it must document attempts to comply. During an interview on 6/13/2022 at 11:37 AM, when queried the last time the agency's emergency preparedness plan was reviewed and/or updated, person 4 (emergency preparedness manager) indicated it was reviewed about 3 years ago, and there was nothing at all done since COVID-19 started.		tooutage of telephone/electricity. D) Security incidents, bomb threats, or civildistubances. E) Staff shortage In the event Healthmasters telephone or utility service areinterrupted: a) Staff will contact the repair company informing them of the nature of ourservices,requesting priority rating for restoring service. b) Telephone call will be forwared to our answeringservice or alternate number if possible. Healthmasters has contracted with Medical Exchange Answering Service Inc, willoperate when ever our office phones are off line. Staff and patients haveadministrator' cell phone number and have 24hour 7day/wk access to bothadministrator/alternate c) Staff will utilize pagers, mobile telephones, orpersonal telephones to contact clients, and arrange to provide needed services.	

			d) If utilities are interrupted, Administrator willtransfer the calls to the answering service, and follow procedures establishedfor on-call hours. In the event of damage to the office, the administrator willmake arrangements for an alternate location. Operations will continue from thealternate site. Secure transfer of client /and or personnel records(if needed). Links to local community organization that may be needed toassist Healthmasters in assisting our clients needs or may need help to respondto community needs. The alternate Administrator will monitor this policy, this will be on-going 00000000000	
E0006	Plan Based on All Hazards Risk Assessment 403.748(a)(1)-(2),482.15(a)(1)-(2),485.625(a)(1)-(§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2),	E0006	Healthmasters hasupdated its policies and guidelines toinclude a Emergency Preparedness Management Policy, which includes a covid 19pandemic policy. This will be reviewed and/or updated at	2022-08-31

	§460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(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) [(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:] (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 Hospices at §418.113(a):] Emergency Plan. The Hospice 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. (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. *[For LTC facilities at §483.73(a):] 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,		lease every two(2)years. All staff will be oriented to the emergency management plan and theirassociated responsibilities. Reviews will be held at least annually. Healthmasterswill conduct a community – based risk assessment to identify potential emergencies (identifiedfor our area) , and the effects these emergencies could have on our clientservices. Purpose: 1) Establish guidelines for client care during anemergency or disaster. 2) Provide direction/instructions for staff tofollow during life-threatening situations, which could disrupt home careservices. 3) Develop disaster readiness and emergencymanagement. 4) Identify healthmasters relationship to a community wide EMP. Situations which can constitute an emergency , include ,butnot limited to:	

	including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] 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. Based on record review and interview, the agency failed to ensure the emergency preparedness plan included a current facility-based or community-based risk assessment, which included the COVID-19 pandemic; or strategies for addressing emergency events identified by the risk assessment or the COVID-19 pandemic. Findings include: An undated agency policy received on 6/09/2022 titled "Disaster/Emergency Preparedness" indicated the agency's emergency preparedness plan shall be based on, and include a documented community based risk assessment, and strategies for addressing emergency events identified in the risk assessments. During an interview on 6/13/2022 at 11:37 AM, when queried the last time a hazard vulnerability risk assessment (HVA) was completed/modified for the agency's patient population and geographic area(s) served, person 4 (emergency preparedness manager) indicated the HVA was old (on or about 2017), and he was unaware it must be based on, and		A) Floods,tornadoes,hurricanes,blizzards, andstorms. B) Natural disasters C) Communications systems/utilities failure due tooutage of telephone/electricity. D) Security incidents, bomb threats, or civildistubances. E) Staff shortage In the event Healthmasters telephone or utility service areinterrupted: a) Staff will contact the repair company informing them of the nature of ourservices,requesting priority rating for restoring service. b) Telephone call will be forwared to our answeringservice or alternate number if possible. Healthmasters has contacted with Medical Exchange Answering Service Inc, willoperate when ever our office phone are off line. Staff and patients haveadministrator' cell phone number and have 24hour	

	include a documented community based HVA. When queried if there were documented strategies for all of the emergency events identified in the agency's HVA, person 4 indicated he was unaware that all events needed a contingency plan. When queried if the HVA included the COVID-19 pandemic, person 4 indicated it did not.		bothadministrator/alternate c) Staff will utilize, mobile telephones, orpersonal telephones to contact clients, and arrange to provide needed services. d) If utilities are interrupted, Administrator willtransfer the calls to the answering service, and follow procedures establishedfor on-call hours. In the event of damage to the office, the administrator willmake arrangements for an alternate location. Operations will continue from thealternate site. Secure transfer of client /and or personnel records(if needed). Links to local community organization that may be needed toassist Healthmasters in assisting our clients needs or may need help to respondto community needs. alternate Administrator will monitor this policy, policy will be on-going 00000000000	

E0013	Development of EP Policies and Procedures 403.748(b),482.15(b),485.625(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [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. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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 annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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	E0013	Healthmasters hasupdated its policies and guidelines toinclude a Emergency Preparedness Management Policy, which includes a covid 19pandemic policy. This will be reviewed and/or updated at lease every two(2)years. All staff will be oriented to the emergency management plan and theirassociated responsibilities. Reviews will be held at least annually. Healthmasterswill conduct a community – based risk assessment to identify potential emergencies (identifiedfor our area) , and the effects these emergencies could have on our clientservices. Purpose: 1) Establish guidelines for client care during anemergency or disaster. 2) Provide direction/instructions for staff tofollow during life-threatening situations, which could disrupt home careservices. 3) Develop disaster readiness and emergencymanagement. 4) Identify healthmasters relationship to a community	2022-08-31

	address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the home health agency failed to maintain current emergency preparedness policies and procedures, with review and update(s) at least every 2 years. Findings include: An undated agency policy received on 6/09/2022 titled "Disaster/Emergency Preparedness" indicated the agency shall document emergency events and revise the emergency plan as needed. The policy failed to include any information about COVID-19. During an interview on 6/13/2022 at 11:37 AM, when queried when the last time the emergency preparedness program was reviewed/updated, person 4 (emergency preparedness manager) indicated it was reviewed about 3 years ago, and not at all since COVID-19 started.		wide EMP. Situations which can constitute an emergency , include ,butnot limited to: A) Floods,tornadoes,hurricanes,blizzards, andstorms. B) Natural disasters C) Communications systems/utilities failure due tooutage of telephone/electricity. D) Security incidents, bomb threats, or civildistubances. E) Staff shortage In the event Healthmasters telephone or utility service areinterrupted: a) Staff will contact the repair company informing them of the nature of ourservices,requesting priority rating for restoring service. b) Telephone call will be forwared to our answeringservice or alternate number if possible. Healthmasters has contacted with Medical Exchange	

			Answering Service Inc, willoperate when ever our office phone are off line. Staff and patients haveadministrator' cell phone number and have 24hour 7day/wk access to bothadministrator/alternate c) Staff will utilize, mobile telephones, orpersonal telephones to contact clients, and arrange to provide needed services. d) If utilities are interrupted, Administrator willtransfer the calls to the answering service, and follow procedures establishedfor on-call hours. In the event of damage to the office, the administrator willmake arrangements for an alternate location. Operations will continue from thealternate site. Secure transfer of client /and or personnel records(if needed). Links to local community organization that may be needed toassist Healthmasters in assisting our clients needs or may need help to respondto community needs. the alternate Administrator will monitor this policy; policy will	

			be on-going 00000000000	
E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(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:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. Based on record review and interview, the agency's emergency preparedness policies and procedures failed to include contingency plans for provision of uninterrupted care for patients with suspected/confirmed COVID-19. Findings include: An undated agency policy received on 6/09/2022 titled "Disaster/Emergency Preparedness" failed to include contingency plans for patients with suspected/confirmed COVID-19.	E0017	**Healthmasters has updated its policies and guidelines to include a EmergencyPreparedness Management Policy, which includes a covid 19 pandemic policy. Thiswill be reviewed and/or updated at lease every two(2) years. All staff will beoriented to the emergency management plan and their associatedresponsibilities. Reviews will be held at least annually. Healthmasters willconduct a community – based risk assessment to identify potentialemergencies (identified for our area) , and the effects these emergenciescould have on our client services. Purpose:**1) Establishguidelines for client care during an emergency or disaster.2) Providedirection/instructions for staff to follow during life-threatening situations,which could disrupt home care services.3) Developdisaster readiness and emergency	2022-08-29

	An agency policy titled "2022 Coronavirus [COVID-19] Policy" stated "[Patients] ... If anyone in your household in [sic] experiencing cold like symptoms ... notify staff so services can be paused ... It is vital for all of us to follow the CDC [center for disease control and prevention] recommendations ...." The document failed to include CDC recommendations to which the agency would follow, or how the patients' needs would be met. During an interview on 06/09/2022 at 2:13 PM, when queried if the agency had any other policies other than the policy titled "2022 Coronavirus [COVID-19] Policy", the administrator stated "No ....", and indicated COVID-19 was new, and It kept evolving. During an interview on 6/13/2022 at 11:37 AM, when queried when the last time the agency's emergency plan was reviewed, person 4 (emergency preparedness manager) indicated it was reviewed about 3 years ago, and not at all since COVID-19 started.		management.4) IdentifyHealthmasters relationship to a community wide EMP.Situationswhich can constitute an emergency, include, but not limited to:A) Floods,Tornadoes, hurricanes, blizzards, and storms.B) NaturaldisastersC) Communicationssystems/utilities failure due to outage of telephone/electricity.D) Securityincidents, bomb threats, or civil disturbance.E) StaffshortageIn theevent Healthmasters telephone or utility service are interrupted:a) Staffwill contact the repair company informing them of the nature of our services, requesting priority rating for restoring service.b) Telephonecall will be forwarded to our answering service or alternate number ifpossible.Healthmastershas contacted with Medical Exchange Answering Service Inc, who willoperate whenever our office phone are off line. Staff and patients haveadministrator' cell phone number and have 24hour 7day/week access to bothadministrator/alternatec) Staffwill utilize, mobile telephones, or personal telephones to contact clients,	

			andarrange to provide needed services.d) Ifutilities are interrupted, Administrator will transfer the calls to theanswering service, and follow procedures established for on-call hours.In theevent of damage to the office, the administrator will plan for an alternatelocation. Operations will continue from the alternate location site. Securetransfer of client /and or personnel records(if needed).Links tolocal community organization that may be needed to assist Healthmasters inassisting our clients needs or may need help to respond to communityneeds. POLICYHealthmasters will act to reduce the risk of further spreading of the COVID-19virus within the agency and the community. The agency will follow universalprecautions and recommended practices while adhering to local, state andfederal guidelines during the pandemic.COVID-19is transmitted through air borne droplets (sneezing, coughing), butindirect contact throughs hand transfer from contaminated surfaces to mucosal surfces(such as nose and mouth) can occur. the virus can transfer between people	

			whoare in close contact with one another (within 6 feet apart). Symptoms rangefrom mild to severe pneumonia and septic shock. There have been reports ofindividuals who have no symptoms. Based on this information, the procedure theagency will put in place address, prevention, protection, and control.PROCEDURE1. Theagency will incorporate COVID-19 protections and procedures into the existinginfection control plan for the agency. This will address training all staff andclients to the steps needed for protection and prevention of spread of thedisease.2. Nowthat vaccines are available, the most important thing staff can do is get aCIOVID-19 vaccine when it is availableto them. This also means encouraging clients to get the vaccine when available3. Healthcare workers will continue to follow CDC guidelines for wearing personalprotective equipment when providing care to clients.4. Agencieswill assure that staff have access to appropriate personal protective equipmentfor themselves and clients. Supplies and personal protective equipment include:	

			a.Surgical mask b. N95face mask/respirator (as needed) c.Gloves d.Goggles and disposable gowns as needed when dealing with clients who have the illness. e. Antimicrobialsoaps and alcohol- based hand hygiene products f.other disposables g. Clothmask may also be used and should be laundered after each use. h.Follow your personal protective equipment for universal precautions policy for detail.5. whenmaking home visits, agencies will identify clients at risk of having theinfection before or Immediately upon arrival at the home.Agencies will ask client the following:**a. Has the client/family traveled internationallywithin the past 14 days?**Forinformation on affected countries visit: https://www.cdc.gov/coronavirus/2019-nCoV/index.html**b. Does the client or family member havesigns or symptoms of a respiratory**Infection?(specifically, fever, cough, dyspnea, and sore throat) there reports of othersymptoms but these	

			primary ones.6. Clientsrequire emergency medical attention if the following occurs: a. Difficultyin breathing/shortness of breath. b.persistent pain or pressure in the chest. c. New confusionor inability to arouse d. bluishlips or face e.Any other concerning sign or symptoms7. Homecare agency staff should follow the standard precautions, including a.Hand hygiene: wash hands before and after client contact, contact with any potentially infectious material, before and after donning protective equipment, including gownsand mask. Hand hygiene includes washing hands with soap and water(20 sec) at these time points, and ifnot possible use the alcohol -based products. b. gloves: wear gloves for any contact withpotentially infectious material (Secretion, tissues, linens)**c. Gowns: should be worn with client careswhere contact with body fluids is likely, including respiratory secretionsd. Note: attached handouts on**	

			sequence forputting on and taking off PPE, these references are from CDC8. Staffmembers with signs and symptoms of a respiratory infection should not reportfor work. 9. If staff develop signs and symptoms of arespiratory infection while at work they should: a. immediatelystop work, put on face mask and isolate at home b. inform the agency's clinical manager of informationon individuals, equipment and locations the staff member had contact with; and c. Contact and follow the localhealth departments recommendations for next steps (testing, locationsfor treatment)10. Criteria for return to work for personnelwith suspected or confirmed COVID-19 based on CDC Guidelines.**a. Symptom based strategy- exclude fromwork until:** · **Atlease 3days (72 hours) have passed-defined as resolution of fever without theuse fever reducing medication and improvement in Respiratory symptoms**· **Atleast 10 days have passed since symptoms first appeared b.**	

			Test based strategy: · **Resolutionof fever without the use of fever reducing medications**· **Improvementin respiratory symptoms** · **Negativeresults of an FDA Emergency use authorized COVID-19 test from at least twoconsecutive respiratory specimens collected 24 hours apart.** **c. Health care personal with laboratoryconfirmed COVID-19 who have not had any symptoms:**· **10days have passed since the date of their first positive diagnostic testassuming they have not developed symptoms since their positive test**· **Negativeresults from at least two consecutive respiratory specimens collected 24 hr.apartd. After returning to work, health care personnelshould wear a face mask at all times at work.e. Self- monitor for symptoms and seekre-evaluation from occupational health if symptoms recur or worsen.** Administratorand Alternate Administrator will monitor this policy, policy is on-going	

E0024	Policies/Procedures-Volunteers and Staffing 403.748(b)(6),482.15(b)(6),485.625(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(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 facilities]. 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.	E0024	Healthmasters hasupdated its policies and guidelines toinclude a Emergency Preparedness Management Policy, which includes a covid 19pandemic policy. This will be reviewed and/or updated at lease every two(2)years. All staff will be oriented to the emergency management plan and theirassociated responsibilities. Reviews will be held at least annually. Healthmasterswill conduct a community – based risk assessment to identify potential emergencies (identifiedfor our area) , and the effects these emergencies could have on our clientservices. Purpose: 1) Establish guidelines for client care during anemergency or disaster. 2) Provide direction/instructions for staff tofollow during life-threatening situations, which could disrupt home careservices.	2022-08-31

	*[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 develop and maintain an emergency preparedness communication plan which included the use of volunteers or other emergency staffing in the event of an emergency to ensure the healthcare needs of the patients were met. Findings include: An undated agency policy received on 6/09/2022 titled "Disaster/Emergency Preparedness" failed to include the procedure for, or the use of volunteers or other emergency staffing in the event of an emergency to ensure the healthcare needs of the patients were met. During an interview on 6/13/2022 at 11:37 AM, when queried if the agency had a procedure for, or a list of volunteers for staffing during an emergency, person 4 (emergency preparedness manager) indicated they did not.		3) Develop disaster readiness and emergencymanagement. 4) Identify healthmasters relationship to a community wide EMP, utilizeour listings in our network agency, public agencies(fire dept., Health dept., hospitals, Utilize individual patient volunteer listings(to include address, phonenumber, relation to patient) Situations which can constitute an emergency , include ,butnot limited to: A) Floods,tornadoes,hurricanes,blizzards, andstorms. B) Natural disasters C) Communications systems/utilities failure due tooutage of telephone/electricity. D) Security incidents, bomb threats, or civil disturbances. E) Staff shortage In the event Healthmasters telephone or utility service areinterrupted: a) Staff will contact the repair	

company informing them of the nature of ourservices,requesting priority rating for restoring service.

b) Telephone call will be forwared to our answeringservice or alternate number if possible.

Healthmasters has contacted with Medical Exchange Answering Service Inc, willoperate when ever our office phone are off line. Staff and patients haveadministrator' cell phone number and have 24hour 7day/wk access to bothadministrator/alternate

c) Staff will utilize, mobile telephones, orpersonal telephones to contact clients, and arrange to provide needed services.

d) If utilities are interrupted, Administrator willtransfer the calls to the answering service, and follow procedures establishedfor on-call hours.

In the event of damage to the office, the administrator willmake arrangements for an alternate location. Operations will continue from thealternate

			/and or personnel records(if needed). Links to local community organization that may be needed toassist Healthmasters in assisting our clients needs or may need help to respondto community needs. the Alternate Administrator will monitor this policy, policy is on-going 00000000000	
E0030	Names and Contact Information 403.748(c)(1),482.15(c)(1),485.625(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following:	E0030	**Healthmasters has updated its policies andguidelines to include a Emergency Preparedness Management Policy, whichincludes a covid 19 pandemic policy. This will be reviewed and/or updated atlease every two(2) years. All staff will be oriented to the emergency managementplan and their associated responsibilities. Reviews will be held at leastannually. Healthmasters will conduct a community – based risk assessment to identify potential emergencies (**	2022-08-23

	(i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff.		**identified for our area) , and theeffects these emergencies could have on our client services. Purpose:** **1) Establishguidelines for client care during an emergency or disaster.** **2) Providedirection/instructions for staff to follow during life-threatening situations,which could disrupt home care services.** **3) Develop disasterreadiness and emergency management.** **4) Identifyhealthmasters relationship to a community wide EMP, utilize our listingsin our network agency, public agencies(fire dept., Health dept.,hospitals, Utilize individual patient volunteer listings(to includeaddress,phone number, relation to patient) , patient physician (name , contactinformation) Healthmasters has developed a CLIENT EMERGENCY INFORMATION form tobe used for listings in client home, and client flies.**	

	(ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers.		**Healthmasters has developed a: communication Plan forEmergency Preparedness.** **POLICY: As part of the overall emergency disaster plan,Healthmasters has established and, will maintain a communication plan that complieswith Federal, State and local laws , and will be reviewed and updated at leastevery two(2) years.** **1. The communication plan must include allof the following :** - **Staff** - **Entities providing services under arrangement** - **Client’s physicians** - **Volunteers, family caregivers** **2. Contact information for the following :** - **Federal, State, Tribal, regional or localemergency preparedness staff** - **Other sources of assistance** **3. Primary and alternate**	

	(iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). Based on record review and interview, the home health agency failed to develop and maintain an emergency preparedness communication plan which included names and contact information for patients' physicians, or volunteers. Findings include: An undated agency policy received on 6/09/2022 titled "Disaster/Emergency Preparedness" failed to include an emergency preparedness communication plan which included names and contact information for patients' physicians, or volunteers. During an interview on 6/13/2022 at 11:37 AM, when queried if the agency's emergency preparedness communication plan included names and contact information for patients' physicians, or volunteers, person 4 (emergency preparedness manager) indicated it did not.		**means for communicatingwith the agency's staff, Federal, State, tribal, regional, and local emergencymanagement agencies** **4. Methods for sharing /** **Situations which can constitute an emergency , include,but not limited to:** **A) Floods,tornadoes,hurricanes,blizzards,and storms.** **B) Natural disasters** **C) Communicationssystems/utilities failure due to outage of telephone/electricity.** **D) Security incidents,bomb threats, or civil disturbances.** **E) Staff shortage** **In the event Healthmasters telephone or utility serviceare interrupted:**	

			a) Staffwill contact the repair company informing them of the nature of ourservices,requesting priority rating for restoring service. **b) Telephone call willbe forwared to our answering service or alternate number if possible.** **Healthmasters has contacted with Medical ExchangeAnswering Service Inc, will operate when ever our office phone are off line.Staff and patients have administrator' cell phone number and have 24hour7day/wk access to both administrator/alternate** **c) Staff willutilize, mobile telephones, or personal telephones to contact clients, andarrange to provide needed services.** **d) If utilities areinterrupted, Administrator will transfer the calls to the answering service,and follow procedures established for on-call hours.** **In the event of damage to the**	

			make arrangements for an alternate location. Operations will continue fromthe alternate site. Secure transfer of client /and or personnel records(ifneeded). **Links to local community organization that may be neededto assist Healthmasters in assisting our clients needs or may need help torespond to community needs.** **Plan is currently developed and in use.** **Administrator will monitor this policy, policy is ongoing.**	
E0032	Primary/Alternate Means for Communication 403.748(c)(3),482.15(c)(3),485.625(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3),	E0032	**Healthmasters has updated**	2022-08-31

	§483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. Based on record review and interview, the home health agency failed to develop and maintain an emergency preparedness communication plan which included an alternate means for communicating with agency staff. Findings include: An undated agency policy received on 6/09/2022 titled "Disaster/Emergency Preparedness" indicated during an emergency, the agency shall attempt to contact staff, and it must inform the staff of a designated local radio/television designation for use during an event of loss of telephone service. During an interview on 6/13/2022 at 11:37 AM, when queried if the agency coordinated with a local radio station for emergency communication needs, the alternate		**its policies andguidelines to include a Emergency Preparedness Management Policy, whichincludes a covid 19 pandemic policy. This will be reviewed and/or updated atlease every two(2) years. All staff will be oriented to the emergency managementplan and their associated responsibilities. Reviews will be held at leastannually. Healthmasters will conduct a community – based risk assessment to identify potential emergencies (identified for our area) , and theeffects these emergencies could have on our client services. Purpose:** **1) Establishguidelines for client care during an emergency or disaster.** **2) Providedirection/instructions for staff to follow during life-threatening situations,which could disrupt home care services.** **3) Develop disasterreadiness and emergency management.** **4) Identifyhealthmasters**	

	administrator and person 4 indicated they did not.		**wide EMP, utilize our listingsin our network agency, public agencies(fire dept., Health dept.,hospitals, Utilize individual patient volunteer listings(to includeaddress,phone number, relation to patient) , patient physician (name , contactinformation) Healthmasters has developed a CLIENT EMERGENCY INFORMATION form tobe used for listings in client home, and client flies.** **Healthmasters has developed a: communication Plan forEmergency Preparedness.** **POLICY: As part of the overall emergency disaster plan,Healthmasters has established and, will maintain a communication plan that complieswith Federal, State and local laws , and will be reviewed and updated at leastevery two(2) years.** **1. The communication plan must include allof the following :** - **Staff**	

			- **Entities providing services under arrangement** - **Client's physicians** - **Volunteers, family caregivers** **2. Contact information for the following :** - **Federal, State, Tribal, regional or localemergency preparedness staff** - **Other sources of assistance** **3. Primary and alternate means for communicatingwith the agency's staff, Federal, State, tribal, regional, and local emergencymanagement agencies** **4. Methods for sharing /** **Situations which can constitute an emergency , include,but not limited to:** **A) Floods,tornadoes,hurricanes,blizzards,and storms.** **B) Natural disasters** **C)**	

			Communicationssystems/utilities failure due to outage of telephone/electricity. **D) Security incidents,bomb threats, or civil disturbances.** **E) Staff shortage** **In the event Healthmasters telephone or utility serviceare interrupted:** **a) Staffwill contact the repair company informing them of the nature of ourservices,requesting priority rating for restoring service.** **b) Telephone call willbe forwared to our answering service or alternate number if possible.** **Healthmasters has contacted with Medical ExchangeAnswering Service Inc, will operate when ever our office phone are off line.Staff and patients have administrator' cell phone number and have 24hour7day/wk access to both administrator/alternate** **c) Staff willutilize, mobile**	

			telephones to contact clients, andarrange to provide needed services. Healthmasters will reconnect with tigerconnect,a service that will provide phone service for staff when local service is off line. **d) If utilities areinterrupted, Administrator will transfer the calls to the answering service,and follow procedures established for on-call hours.** **In the event of damage to the office, the administratorwill make arrangements for an alternate location. Operations will continue fromthe alternate site. Secure transfer of client /and or personnel records(ifneeded).** **Links to local community organization that may be neededto assist Healthmasters in assisting our clients needs or may need help torespond to community needs.** **Administrator will monitor this policy, policy is ongoing.**	

E0036	EP Training and Testing 403.748(d),482.15(d),485.625(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this	E0036	Healthmasters has updated its Disaster plan Orientation andTraining POLICY: All employees will be oriented to the emergency Disasterplan (EDP), including their responsibilities in carrying out the plan. This orientationwill be provided upon hire-during orientation, and will participate in agencyemergency preparedness plan in- service educational sessions annually. PROCEDURE Healthmasters will develop an emergency preparedness trainingprogram based on the Emergency Disaster plan, Communication plan and EmergencyDisaster policies and procedures.	2022-08-31

	must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the home health agency failed to maintain an emergency preparedness training and testing program, that was reviewed and/or updated at least annually, per the agency's own policy. Findings include: An undated agency policy received on 6/09/2022 titled "Disaster/Emergency Preparedness" indicated the agency shall review the emergency plan annually, testing would occur annually. During an interview on 6/13/2022 at 11:37 AM, when queried when the last time the emergency preparedness program/plan was		Initial Emergency Disaster preparedness training will beprovided to all new and existing staff, individuals providing services underarrangement and volunteers consistentwith their expected roles in the agency. Emergency Disaster preparedness training will be provided atleast every Two(2) years. The agency will maintain documentation of allemergency Disaster preparedness training provided. Attendance and demonstrationof staff knowledge of emergency procedures will be notated in employee’s personnelfile. POLICIES AND PROCEDURES: Healthmasters must develop and implement emergencypreparedness policies and procedures based on the emergency plan developed thatincludes risk assessment and communication plan. The policies and proceduresmust be reviewed	

	reviewed, person 3 (emergency preparedness manager) indicated it was reviewed about 3 years ago, and nothing at all was done since COVID-19 started.		and updated at least every two years. AT A minimum thepolicies must address the following: The plans for the agency's client during a natural orman-made disaster. Individual plans for each client must be included as part ofthe comprehensive client assessment,which must be conducted according to the provisions of 484.55 The procedures to inform State and local emergencypreparedness officials about agency clients in need of evacuation from theirresidences at any time due to an emergency situation based on the client'smedical and psychiatric condition and home environment. The use of volunteersin an emergency or other emergency staffing strategies, including the processand role for integration of state or federal designated health careprofessionals to address surge needs during an emergency. Administrator will monitor ;	

			on going	
E0037	EP Training Program 403.748(d)(1),482.15(d)(1),485.625(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), §485.625(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, "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 procedures are significantly updated, the [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	E0037	Healthmasters has updated its Disaster plan Orientation andTraining POLICY: All employees will be oriented to the emergency Disasterplan (EDP), including their responsibilities in carrying out the plan. This orientationwill be provided upon hire-during orientation, and will participate in agencyemergency preparedness plan in- service educational sessions annually. PROCEDURE Healthmasters will develop an emergency preparedness trainingprogram based on the Emergency Disaster plan, Communication plan and EmergencyDisaster policies and procedures. Initial Emergency Disaster preparedness training will beprovided to all new and	2022-08-31

	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. (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		existing staff, individuals providing services underarrangement and volunteers consistentwith their expected roles in the agency. Emergency Disaster preparedness training will be provided atleast every Two(2) years. The agency will maintain documentation of allemergency Disaster preparedness training provided. Attendance and demonstrationof staff knowledge of emergency procedures will be notated in employee’s personnelfile. POLICIES AND PROCEDURES: Healthmasters must develop and implement emergencypreparedness policies and procedures based on the emergency plan developed thatincludes risk assessment and communication plan. The policies and proceduresmust be reviewed and updated at least every two years. AT A minimum thepolicies must address the following:	

	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: (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.		The plans for the agency's client during a natural orman-made disaster. Individual plans for each client must be included as part ofthe comprehensive client assessment,which must be conducted according to the provisions of 484.55 The procedures to inform State and local emergencypreparedness officials about agency clients in need of evacuation from theirresidences at any time due to an emergency situation based on the client'smedical and psychiatric condition and home environment. The use of volunteersin an emergency or other emergency staffing strategies, including the processand role for integration of state or federal designated health careprofessionals to address surge needs during an emergency. Administrator will monitor this policy; on-going	

	(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			

emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.

Based on record review and interview, the agency failed to ensure emergency preparedness training was provided at least annually (per the agency's own policy), or more often as needed; or maintained documentation of all emergency preparedness training.

Findings include:

An undated agency policy received on 6/09/2022 titled "Disaster/Emergency Preparedness" indicated agency employees would be oriented on the emergency plan during the new hire process and annually thereafter.

During an interview on 6/09/2022 at 2:44 PM, employee record reviews were completed with person 3 (human resource manager) and the alternate administrator. The records failed to include documentation of any annual in-service training. When queried where annual in-service training was documented, the alternate administrator indicated it was documented in an agency in-service binder.

During an interview on 6/09/2022 at 3:40 PM, when queried if the agency had a separate in-service book for training, person 3 said "Yes."

During an interview on 6/13/2022 at 11:37 AM, when queried when the last time emergency preparedness training was completed with employees, person 4 indicated it was about 3 years ago. When queried if the training was documented in the emergency preparedness binder, person 3 stated "No".

During an interview on 6/13/2022 at 4:08 PM, when the agency in-service binder was

	administrator stated "... We had one, but I don t know where it is ...." When queried when the last in-service was conducted, the alternate administrator stated "... I don't know ... A long time ...."			
E0039	EP Testing Requirements 403.748(d)(2),482.15(d)(2),485.625(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), §485.625(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, 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:	E0039	Healthmasters Emergency Preparedness Disaster PlanOrientation and Training: TESTING: Healthmasters must conduct exercises to test the emergencyplan AT LEAST ANNUALLY. Healthmasters must do the following: Participate in a full- scale exercise that is communitybased; or When a community based exercise is not accessible, conductan annual individual, agency based functional exercise every two(2) years or ;	2022-08-31

	(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 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		If Healthmasters experiences an actual natural or man-madeemergency that requires activation of the emergency plan, the agency is exemptfrom engaging in its next required full-scale community based function exercise following the onset of theemergency event. Conduct an additional exercise every 2 years, opposite theyear the full-scale or functional exercise is conducted. This may include, butis not limited to: A second full-scale exercise that is community based or anindividual, agency based functional exercise or A mock disaster drill A tabletop exercise or workshop thatis led by a facilitator andincludes a group discussion, using a narrated , clinically relevant emergencyscenario , and a set of problem statements, directed messages, or preparedquestions designed to challenge an emergency plan. Analyze the agency’s response to and maintain documentationof all drills,	

	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 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		tabletop exercises, and emergency events, and revise the agency'semergency plan as needed. alternate Administrator will monitor this policy; on-going	

	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 requires activation of the emergency plan, the [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) 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, 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 by a facilitator 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 [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			

	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 record review and interview, the agency failed to evidence it conducted exercises to test the emergency plan annually.			

	Findings include: An undated agency policy received on 6/09/2022 titled "Disaster/Emergency Preparedness" indicated the agency shall execute the disaster/emergency preparedness plan annually, and participate in a full scale or table-top exercise. During an interview on 6/13/2022 at 11:37 AM, when queried when the agency last conducted a full scale or table-top exercise, person 4 (emergency preparedness manager) indicated November 2018 was the last exercise.			
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: (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	N0458	PERSONNEL RECORDS Policy: updated Personnel files will be established and maintained for allpersonnel. All information will be considered confidential and made available to authorized personnelonly. All client-identifying data will be removed from employee personnelrecords. Personnel records may not be removed from agency unless ordered bysubpoena. Purpose: To provide a mechanism for	2022-08-23

	home health agency failed to ensure all employee records were kept current and included copies of current licenses/certifications (HHAs 1, 2, and 3), and/or annual performance evaluations for 5 of 5 employee records reviewed (registered nurse [RN] 2, licensed practical nurse [LPN] 1, and home health aides [HHAs] 1, 2, 3). Findings include: 1. A review of LPN 1 s personnel record failed to evidence an annual evaluation and failed to evidence a current biannual license renewal. During an interview on 6/9/22 at 2:40 PM, Person 3 indicated LPN 1 s annual evaluation was due on 3/22/22 and indicated LPN 1 s license expired on 10/31/20. 2. A review of RN 2 s personnel record failed to evidence a job description for the alternate clinical manager, an annual evaluation, and current biannual license renewal. During an interview on 6/9/22 at 2:50 PM, Person 3 confirmed RN 2 s personnel record failed to contain the documents and indicated RN 2 s license expired on 10/31/2019. 3. A review of HHA 3 s employee record failed to evidence an annual evaluation after 2018 and a current HHA certification. During an interview on 6/9/22 at 3:04 PM, Person 3 confirmed the personnel record failed to contain the documents and indicated HHA 3 s certification expired in 2021.		complete,and current personnel information. SPECIAL INSTRUCTIONS 1. Personnel records: a. The personnel records for an employee willinclude, but not be limited to b. Pre-employment information: · Employment Application(signed and dated) · Interview documentation · Reference checks · Criminal history and background checks asrequired by law · Credentials c. Employment information: · Employment letter · Competency testing for home health aides andspecific competencies per job title · LICENSE and certifications · CPR certification	

	4. A review of HHA 1 s employee record failed to evidence a current CNA/HHA certification. During an interview on 6/9/22 at 3:20 PM, Person 3 confirmed the personnel record failed to contain the document. 5. A review of HHA 2 s employee record failed to evidence an annual evaluation after 2018 or a current CNA/HHA certification. During an interview on 6/9/22 at 3:35 PM, Person 3 confirmed the personnel record failed to contain the documents.		· Signed job description · Skills checklist · Orientation checklist (completed and signed) · Confidentiality statement (signed) · Conflict of interest statement (signed) · Employee benefits information · I-9 and payroll information d. Ongoing Employment : · PERFORMANCE APPRAISALS · Updated job descriptions · Education record · In-services · Updated LICENSE/CERTIFICATION · Competency reviews · Commendations · Disciplinary action foms · Incident reports e. MEDICAL HISTORY/Health	

			status- maintainedconfidentially: · Pre-employment · Physical · Hepatitis B declination or immunization record · TB screening(2-step Mantoux if required) , chestx-ray or evidence of treatment · Drug screening f. Employment: · Ongoing immunization and TB testing, TBscreening if positive Mantoux · Illness record · Attendance(optional) · Workers compensation claims · Criminal background (as required0 Release of Employee information: 1. Internal: a. Personnel records are confidential and will bereleased	

			only to responsible management staff for review. Healthmasters has eleven employees: management – 4, RN- 2, Lpn-2, home health aides- 3, total of 11. All of our personnel records have been reviewed for thesedeficient practices(100%). To ensure this does not recur, we will monitor and review personnelfiles monthly(alternate administrator, Personnel Manager). All Annual evaluations have been completed, all Licenses forall staff are current,and have been located and add to the personnel files, Jobdescriptions for alternate clinical manager has been added to their file. Alternate Administrator will be responsible formonitoring, ongoing	

PERSONNEL RECORDS

Policy: updated

Personnel files will be established and maintained for allpersonnel. All information will be considered confidential and made available to authorized personnelonly. All client-identifying data will be removed from employee personnelrecords. Personnel records may not be removed from agency unless ordered bysubpoena.

Purpose:

To provide a mechanism for maintaining accurate, complete,and current personnel information.

SPECIAL INSTRUCTIONS

1. Personnel records:

			a. The personnel records for an employee willinclude, but not be limited to b. Pre-employment information: · Employment Application(signed and dated) · Interview documentation · Reference checks · Criminal history and background checks asrequired by law · Credentials c. Employment information: · Employment letter · Competency testing for home health aides andspecific competencies per job title · LICENSE and certifications · CPR certification · Signed job description · Skills checklist · Orientation checklist (completed and signed) · Confidentiality statement	

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To provide a mechanism for maintaining accurate, complete,and current personnel information.

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allpersonnel. All information will be considered confidential and made available to authorized personnelonly. All client-identifying data will be removed from employee personnelrecords. Personnel records may not be removed from agency unless ordered bysubpoena.

Purpose:

To provide a mechanism for maintaining accurate, complete,and current personnel information.

SPECIAL INSTRUCTIONS

1. Personnel records:

a. The personnel records for an employee willinclude, but not be limited to

b. Pre-employment information:

· Employment Application(signed and dated)

· Interview documentation

· Reference checks

			· Criminal history and background checks asrequired by law · Credentials c. Employment information: · Employment letter · Competency testing for home health aides andspecific competencies per job title · LICENSE and certifications · CPR certification · Signed job description · Skills checklist · Orientation checklist (completed and signed) · Confidentiality statement (signed) · Conflict of interest statement (signed) · Employee benefits information · I-9 and payroll information d. Ongoing Employment : · PERFORMANCE APPRAISALS	

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N0464	Home health agency administration/management	N0464	PERSONNEL RECORDS	2022-08-26

	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: (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:		Policy: updated Personnel files will be established and maintained for allpersonnel. All information will be considered confidential and made available to authorized personnelonly. All client-identifying data will be removed from employee personnelrecords. Personnel records may not be removed from agency unless ordered bysubpoena. Purpose: To provide a mechanism for maintaining accurate, complete,and current personnel information. SPECIAL INSTRUCTIONS 1. Personnel records: a. The personnel records for an employee willinclude, but not be limited to b. Pre-employment information:	

	(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 record review and interview, the home health agency failed to ensure it annually evaluated/screened all employees with direct patient contact for tuberculosis (TB) for 5 of 5 employee records reviewed (registered nurse [RN] 2, licensed practical nurse [LPN] 1, home health aide [HHA] 1, HHA 2, and HHA 3). Findings include: 1. An undated agency policy titled "Employee Health Assignments" stated "... After baseline testing, tuberculosis screening must ... be completed annually ... if no exposure to TB is suspected a TB questionnaire may be utilized ... This agency must maintain documentation of tuberculosis evaluations showing that any person ... has had a negative finding on a tuberculosis examination/screening within the previous twelve (12) months ...." 2. A review of LPN 1's personnel record failed to evidence TB testing requirements. 3. A review of RN 2's personnel record failed to evidence TB tests or screenings in 2020 and 2021.		· Employment Application(signed and dated) · Interview documentation · Reference checks · Criminal history and background checks asrequired by law · Credentials c. Employment information: · Employment letter · Competency testing for home health aides andspecific competencies per job title · LICENSE and certifications · CPR certification · Signed job description · Skills checklist · Orientation checklist (completed and signed) · Confidentiality statement (signed) · Conflict of interest statement (signed) · Employee benefits information	

	4. A review of HHA 1's personnel record failed to evidence TB tests or screenings in 2020 or 2021. 5. A review of HHA 2's personnel record failed to evidence TB tests or screenings in 2020 or 2021. 6. A review of HHA 3's personnel record failed to evidence TB tests or screenings in 2020 or 2021. 7. On 6/09/2022 at 2:25 PM, employee records were reviewed with Person 3 (human resource manager). When queried to submit evidence of the agency's employee compliance with TB testing requirements, Person 3 indicated LPN1's last TB test was administered 1/29/2019, and there were no subsequent annual screenings/tests. Person 3 confirmed RN 2's employee record failed to include TB tests or screenings in 2020 or 2021, HHA 3's employee record failed to include TB tests or screenings in 2020 or 2021, HHA 1's employee record failed to include TB tests or screenings after 2019 and HHA 2's employee record failed to include TB tests or screenings after 2019.		· I-9 and payroll information d. Ongoing Employment : · PERFORMANCE APPRAISALS · Updated job descriptions · Education record · In-services · Updated LICENSE/CERTIFICATION · Competency reviews · Commendations · Disciplinary action foms · Incident reports e. MEDICAL HISTORY/Health status-maintainedconfidentially: · Pre-employment · Physical · Hepatitis B declination or immunization record · TB screening(2-step Mantoux if required) , chestx-ray or evidence of treatment(annually)	

			· Drug screening f. Employment: · Ongoing immunization and TB testing, TBscreening if positive Mantoux · Illness record · Attendance(optional) · Workers compensation claims · Criminal background (as required0 Release of Employee information: 1. Internal: a. Personnel records are confidential and will bereleased only to responsible management staff for review. Healthmasters has eight employees having direct patientcontact: management – 1, RN- 2, Lpn- 2, home health aides- 3, total of 8 All of our personnel records have been reviewed for thesedeficient practices(100%). All of the direct patient contact	

			TBevaluation and screening. Testing records have included in their medical records file. To ensure this does not recur, we will monitor and review personnel/medicalfiles monthly(alternate administrator, Personnel Manager). Alternate Administrator will be responsible formonitoring, ongoing	

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 record review and interview, the home health agency failed to develop and implement policies and procedures for the control of COVID-19 (an infectious disease caused by the SARS-CoV-2 virus), a process for tracking and securely documenting the COVID-19 vaccination status of all staff, or contingency plans for staff with no proof they were fully vaccinated for COVID-19. Findings include: An agency policy titled "2022 Coronavirus Policy" stated in its entirety: "Listed below are the policies regarding the 2020 Coronavirus ... Office Staff ... If you are experiencing Any [sic] cold symptoms ([sic] Fever,Cough,Shortness of Breath,Sore Throat or Headache ") [sic] have been in contact with anyone who is sick or traveled to affected places please do not come into the office. Please work from home as needed.If [sic] you need any additional supplies or resources ,please [sic] contact Tract to arrange for those . [sic] ... Clients ... If anyone in your household in [sic] experiencing cold like symptoms(Fever,Cough,Shortness of Breath,Sore Throat or Headache) [sic]. Please notify administrative staff so services can be paused until your symptoms are free for 48 hours or negative test results are provided.	N0470	Healthmasters has updated its COVID 19 Vaccination policy As a condition of participation, CMS requires home healthagencies to develop and implement policies and procedures to ensure that allstaff are fully vaccinated for covid-19. Staff is defined as “individuals whoprovide any care, treatment, or otherservices for the agency or its clients. Fully vaccinated means: Two weeks or more after completing a primary series for Covid-19. Two week or more since the administration of a single dosevaccine or the administration of all required doses of multi-dose vaccine . If the employee is granted an exemption based on recognizedmedical conditions or sincere religious beliefs consistent with federal , themandate will not apply to	2022-08-19

	Please evaluate your household when contacting the administration. We want to keep out [sic] families safe as well as our nurses and home health aides and the clients they see before and after you . [sic] It is vital for all of us to follow the CDC [centers for disease control and prevention] recommendations during this time ... Acknowledgement of Compliance ... [line to sign name]". The policy failed to demonstrate how the agency ensured that all staff were fully vaccinated for COVID-19, a process for tracking and securely documenting the COVID-19 vaccination status of all staff, or contingency plans for staff with no proof they were fully vaccinated for COVID-19. During an interview on 06/09/2022 at 2:13 PM, when queried if the agency had any other policies/procedures for COVID-19 aside from the policy titled "2022 Coronavirus Policy", the alternate administrator stated, "... Um [sic] no ... COVID is new ... It keeps evolving." During an interview on 06/09/2022 at 2:19 PM, person 3 (human resource manager) submitted an undated, untitled document, which, per person 3, was the list of the agency's employees. registered nurse (RN) 2, licensed practical nurse (LPN) 1, home health aide (HHA) 1, HHA 2, and HHA 3 were included on the list, and the list indicated all 5 employees were vaccinated. The administrator/clinical manager was not included on the list. When queried for proof of vaccination, person 3 indicated RN 2 and LPN 1 misplaced their vaccination cards, and he was still waiting for them to submit their cards. At 2:31 PM, when queried about the alternate administrator/clinical manager's proof of vaccination, person 3 indicated he thought her vaccine card "was at home". Surveyor observed submitted copies of vaccination cards for LPN 2 (not on the list), person 3, HHA 1, and HHA 3. Upon survey exit, no proof of vaccination was submitted for the administrator/clinical manager, the alternate administrator, HHA 2, RN 2, or LPN 1. Of 9 total known employees, the agency demonstrated 44% compliance with the COVID-19 vaccine mandate.		them. Regardless of clinical responsibility or client contact, thepolicies and procedures must apply tothe following agency staff, who provide any care, treatment, or other servicesfor the agency and/or its clients. Agency employee License practitioners Students, trainees, and Volunteers Individuals who provide care, treatment, or other servicesfor the agency and /or its clients, under contract or by arrangement. Thisincludes hospice, and dialysis staff, physical , occupational, or speechtherapist , mental health professionals, licensed practitioners or adult student,trainees of volunteers. Healthmasters willtrack and securely document the vaccination status of each staff member,including those for whom there is a temporary delay in vaccination. Staff who are not fully	

			vaccinated will not provide care,treatment, or other services for the agency or its clients until they havecompleted the primary vaccination series for COVID-19 and are considered fullyvaccinated, or at a minimum , have received a single dose vaccine or the firstdose of the vaccination series. All of Healthmasters employees have been vaccinated since the beginning 2022, all of their vaccination record are in theirpersonnel medical files This policy will be monitored by the personnel director, the policy is on-going	
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) 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	N0488	CLIENT DISCHARGE PROCESS POLICY: updated 08-12-2022 Discharge planning is initiated for every home care clientat the time of the client's admission for home care. When clients are admittedfor home care services, the expectation is the client will be- discharged toself-care or care family when goals are met. Discharging a client to	2022-08-26

	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 home health agency failed to develop a policy which required at least fifteen (15) calendar days' notice of discharge be given to the patient/representative, before the services were stopped. Findings include: An undated agency policy titled		anotherprovider is permitted under limited circumstances that are documented in theadmission notices. PURPOSE To facilitate the client's discharge or transfer to anotherentity when circumstances exist that this is the best solution for the client. To ensure continuity of care, treatment and services whenneeded. To assure collaboration with the physician/ allowednon-physician (NPP) ,client and/or representative, family and other disciplinesin planning for discharge from the agency. SPECIAL INSTRUCTIONS Discharge Procedure: 1. Planning for discharge is provided as part ofthe ongoing assessment of needs and in accordance with expected care outcomes.The client/family and/or client representative will participate in this processbeginning with the initial assessment visit.	

	Discharge/Transfer from Service stated, ... an Agency intending to ... discharge a patient shall notify the patient or caregiver and physician no later than five (5) days before the date on which ... discharge will take place ...." During an interview on 6/10/2022 at 10:37 AM, when queried how many days notice is required prior to discharge from home health services, the administrator stated "Five."		2. Client's needs for continuing care to meetphysical and psychological needs are identified and clients are informed in atimely manner (no less than fifteen days advance notice), of the need to planfor discharge or transfer to another level of care/organization. Clients areinformed of the reason for discharge and anticipated needs for service afterdischarge. 3. The physician/allowed non-physician practitioner(NPP) will be involved in the discharge plan and specific ongoing care needs willbe identified and addressed as part of the plan. 4. The impending discharge will be reviewed withother members of the home care team to assure coordination and continuity withthe client and family/caregivers. 5. The Registered Nurse or Therapist shall reviewthe clinical record to assure accuracy and completion. A Discharge plan shallbe developed that is documented in writing and includes all written/verbalinstruction regarding the client's ongoing	

			care needs and available resources providedto the client and family This policy has been updated and put into effect, to documentand ensure that patients are given at least a fifteen-day discharge notice. The policy will be monitored through our to DischargeProcedure, which will involve physicians, members of home care team/family/caregivers.Registered Nurses will review the clinical records to assure accuracy and completeness. This policy will be monitored by the Administrator; policyis on-going	
G0510	Comprehensive Assessment of Patients 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive	G0510	Healthmasters has a small patient census, this allowed theagency to discharge and complete a start of care on the same day. Each of ourpatients will be discharged and re-admitted on same day basis, allowing theagency to bring	2022-08-31

	assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. Based on observation, record review, and interview, the agency failed to ensure the initial comprehensive assessment was completed by a registered nurse (RN) (#1) (see tag G514); failed to ensure the patient s medication list was current, reviewed at least every 60 days, included all medications the patient used, the route, the dose, and/or the indications for use; and/or failed to ensure a drug regimen review was completed to identify duplicate drug therapy, for 6 of 7 clinical records reviewed (#1, 2, 3, 4, 5, 6,) (see tag G536); and failed to ensure the RN completed 2 comprehensive re-assessments for 1 of 1 home visits observed with a patient who received skilled nursing services (#1), and failed to ensure the RN completed multiple comprehensive re-assessment within the last 5 days of every 60 days beginning with the start-of-care date for 5 of 5 home health aide (HHA) only records reviewed (#2, 3, 4, 5, 6) (See tag G546); The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR §484.55: Comprehensive Assessment of Patients.		current oasis into compliance. The agency can now put systemsinto place to ensure that our oasis remains in compliance: 1) Healthmasters has hired another RN, Who has twenty years of home health care experience. 2) The new RN will focus on, Oasis, plans of care,patient medications, contact with physicians and supervisory visits. The new RNwill complete PRN visits as needed. This increase in medical staff will allow the agency tocomplete its comprehensive re-assessment with in the required every 56-60 days. Administrator will be responsible for monitoring , monitoring will be on-going	
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	G0514	Healthmasters hired a RN with Twenty years of home healthcare experience, who will be assigned to assist wth review of oasis for timelycompletion, accurate completion, care plans, patient medication updates, physiciancontact, supervisory	2022-08-31

	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 observation, record review and interview, the agency failed to ensure the initial comprehensive assessment was completed by a registered nurse (RN) for 1 of 1 home visits observed with a patient who received skilled nursing services (#1). Findings include: An undated agency job description received on 6/07/2022, titled Registered Nurse indicated nursing assessment forms must be completed in a timely manner, and patients must be assessed during every home health care visit. An undated agency policy received on 6/13/2022 titled Timeliness and Accuracy of Entries in the Clinical Record stated ... To ensure that a current and accurate clinical record exists for each patient ... All clinicians [includes RN] have a professional and legal duty of care ... record keeping should be able to evidence ... Full account of the assessment ... Relevant information about the condition of the patient at any given time ... Complete clinical progress notes on the date service is rendered .... An undated agency policy received on 6/09/2022 titled Comprehensive Assessment of Patients (OASIS) [outcome assessment and information set] stated ... A comprehensive assessment ... will be performed ... at start of care ... must be performed by a registered nurse ... in conjunction with the ... (OASIS) tool ... completed no later than five calendar days ... Components of a comprehensive assessment includes ... Head to toe assessment ... Vital Signs ... Special nutritional needs or dietary requirements and weight loss ... other symptoms assessment ... Integumentary [skin] status ... Respiratory [lungs/breathing] status ...		visits, and PRN visits. Our low census will assist our Newhired RN to complete Oasis, start of care timely, with initial assessmentrequirements. Our new hired RN will be part of Nursing staff to assist with ourOasis, plans of care, and newly formed review process, which includes the Administrator,and RN. The process will include, over- see for timely completion, check for accuracyof oasis, plans of care, medication checks, supervisory visits, andcommunications with the Physicians. Documentation of all Oasis, plans of care, contact withpatients Physicians, and supervisory visits will be documented in newly formed reviewreport form, which will be submitted to Broad of Directors for review. The Administrator will be responsible for this proceedure, monitoring will be on-going	

Neuro/emotional/behavioral status ... ability to ambulate ... functional limitations ... a complete pain assessment ....

Observation of a home visit occurred on 6/09/2022 at 1:00 PM, with patient #1 and licensed practical nurse (LPN) 1. The patient presented up in a tilted wheelchair with head rest and wrap around leg rests, contractures to both hands, and ankle foot orthotics (AFOs) on both feet (braces to support feet due to foot drop/inability to hold feet up). Equipment observed included a broda chair (special shower chair), a tilt table (used to facilitate weight bearing/leg muscle strengthening), incontinence pads and adult briefs, size 14 fr (french) straight catheter kits (used to obtain urine specimens for lab testing), and g-tube (a tube inserted into the stomach for administration of nutrition, fluids, and/or medications) supplies/dressings. Observation was made of the patient s g-tube insertion site (mic-key button- a special low-profile tube), which was clean and dressed with gauze. During this time, LPN 1 was queried to describe the patient s condition, and the care she provided to the patient. LPN 1 indicated the patient was involved in a severe motor vehicle accident (MVA) many years ago, which resulted in a traumatic brain injury (TBI) and seizures, received supplemental g-tube feedings 4 times daily, the patient was able to eat a soft diet (soft in texture, minimal chewing needed, easy to swallow), followed commands, and she cared for this patient 10 hours daily, 5 days per week.

Clinical record for patient #1 was completed on 6/13/2022, start of care date 2/09/2022. A comprehensive assessment document dated 2/09/2022, titled OASIS ASSESSMENT DETAILS was completed by the agency s clinical manager (a RN). The document indicated the patient experienced pain, and reasons for hospitalization included pain management, but failed to include a comprehensive pain assessment was completed; and failed to indicate the patient s lung sounds, bowel sounds, last bowel movement, g-tube assessment (or presence of), diet, nutrition/hydration status,

psychological/behavioral status, neurological status, mental status, functional limitations, musculoskeletal status, fall risk assessment, activities permitted, or equipment/supply needs were assessed by the RN.

During an interview on 6/13/2022 at 12:49 PM, when queried to describe the patient s nutritional requirements, the clinical manager stated, Through her tube [g-tube]. When queried if the patient received any other route (oral) of nutrition, the clinical manager stated No. When queried to describe what she did during the comprehensive visit on 2/09/2022, the clinical manager stated, I do the OASIS part, check her meds, or anything that was different, then we generate the POC [plan of care]. When queried if the comprehensive document should be fully completed by the RN, the clinical manager stated Yes. When queried why she didn t assess vital signs, the clinical manager indicated the LPN (LPN 1) was there too, so she put it down . When queried why a comprehensive pain assessment wasn t completed (history of hospitalization for pain management and pain was identified during the assessment), the clinical manager indicated the patient hasn t been in the hospital for pain management, and when queried, she indicated the comprehensive assessment document may be incorrect. When queried why she didn t assess lung sounds, she stated, I m not sure. When queried why she didn t assess the patient s last bowel movement, she stated, I don t know . When queried why she didn t assess the patient s musculoskeletal status, she stated Because she can t walk. When queried if equipment/supplies should be assessed during the comprehensive assessment, she stated, Yes.

During an interview on 6/13/2022 at 2:13 PM, when queried what a comprehensive assessment consisted of, the clinical manager stated "My head is swimming ....", and no further information was provided.

During an interview on 6/13/2022 at 3:14 PM,

	assessment consisted of, the alternate administrator (not an RN) indicated it consisted of the OASIS (OASIS tool does not include the physical assessment portion of a comprehensive assessment). The alternate administrator then handed the clinical manager a paper copy of the patient's comprehensive assessment (2/09/2022). The clinical manager was then queried, "When you do a comprehensive assessment, what does that consist of?" The clinical manager replied "Vitals." When queried if she was able to answer without looking at the document, the clinical manager stated "Probably not ... we have an order from the MD, then we take vital signs ...." When queried why she didn t document about the g-tube, the clinical manager stated, "Well it was clean, and it was patent." When queried how she knew it was patent, the clinical manager stated "When we are pushing something in there." When queried if she administered anything into the g-tube during her assessment, she stated "No, the LPN [LPN 1] was there and she had done that already." When queried if she knew the size of the g-tube, she indicated she wasn't sure. When queried if this information should be included in the comprehensive assessment, she stated. "Yes." 17-14-1(a)(1)(A)			
N0518	Patient Rights 410 IAC 17-12-3(e) Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.	N0518	Healthmasters has replaced all its advance Directives withthe revised November 01,2018, all patient will be provided replacement copies, new admissions will receive the November 01/2018 edition. Alternate Administrator will monitor : on-going	2022-08-22

	Based on record review and interview, the home health agency failed to provide all patients with current Indiana Department of Health (IDOH) information on advance directives, with revised date 11/1/2018. Findings include: On 6/09/2022 at 12:00 PM, the alternate administrator submitted the agency's admission packet/home folder for review, which contained a document with revised date May 2004, titled "Indiana State Department of Health ... Advance Directives ...." During an interview on 6/10/2022 at 11:10 AM, when asked if the IDOH information on advance directives, dated May 2004, was the most current information available for patients, the alternate administrator indicated he wasn t sure.			
G0520	5 calendar days after start of care 484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on observation, record review and interview, the agency failed to ensure the initial comprehensive assessment was completed by a registered nurse (RN) for 1 of 1 home visits observed with a patient who received skilled nursing services (#1). Findings include:	G0520	Healthmasters is in the process of completing our hiring procedure for an RN with Twenty years of home healthcare experience, who will be assigned to review and approve oasis timelycompletion, accurate completion, care plans, patient medication updates, physiciancontact, supervisory visits, and PRN visits. Our low census will assist our New RN to complete Oasis, start of care timely, with initial assessmentrequirements. Our	2022-08-31

	An undated agency job description received on 6/07/2022, titled Registered Nurse indicated nursing assessment forms must be completed in a timely manner, and patients must be assessed during every home health care visit. An undated agency policy received on 6/13/2022 titled Timeliness and Accuracy of Entries in the Clinical Record stated ... To ensure that a current and accurate clinical record exists for each patient ... All clinicians [includes RN] have a professional and legal duty of care ... record keeping should be able to evidence ... Full account of the assessment ... Relevant information about the condition of the patient at any given time ... Complete clinical progress notes on the date service is rendered .... An undated agency policy received on 6/09/2022 titled Comprehensive Assessment of Patients (OASIS) [outcome assessment and information set] stated ... A comprehensive assessment ... will be performed ... at start of care ... must be performed by a registered nurse ... in conjunction with the ... (OASIS) tool ... completed no later than five calendar days ... Components of a comprehensive assessment includes ... Head to toe assessment ... Vital Signs ... Special nutritional needs or dietary requirements and weight loss ... other symptoms assessment ... Integumentary [skin] status ... Respiratory [lungs/breathing] status ... Elimination [bowel/urinary] status ... Neuro/emotional/behavioral status ... ability to ambulate ... functional limitations ... a complete pain assessment .... Observation of a home visit occurred on 6/09/2022 at 1:00 PM, with patient #1 and licensed practical nurse (LPN) 1. The patient presented up in a tilted wheelchair with head rest and wrap around leg rests, contractures to both hands, and ankle foot orthotics (AFOs) on both feet (braces to support feet due to foot drop/inability to hold feet up). Equipment observed included a broda chair (special shower chair), a tilt table (used to facilitate		new RN will be part of Nursing staff to assist with ourOasis, plans of care, and newly formed review process, which includes the Administrator,and RN. The process will include, over- see for timely completion, check for accuracyof oasis, plans of care, medication checks, supervisory visits, andcommunications with the Physicians. Client Reassessment/update of Comprehensive Assessment POLICY The Comprehensive assessment will be updated and revised as oftenas the client's condition warrants due to major decline or improvement in healthstatus. Assessment will include OASIS data collection for allMedicare and Medicaid skilled clients. Clients who are not receiving skilled services under the Medicare or Medicaidprogram will be assessed using the Oasis tool or an alternative form identifiedby the agency. Reassessments must be done at least:	

	weight bearing/leg muscle strengthening), incontinence pads and adult briefs, size 14 fr (french) straight catheter kits (used to obtain urine specimens for lab testing), and g-tube (a tube inserted into the stomach for administration of nutrition, fluids, and/or medications) supplies/dressings. Observation was made of the patient s g-tube insertion site (mic-key button- a special low-profile tube), which was clean and dressed with gauze. During this time, LPN 1 was queried to describe the patient s condition, and the care she provided to the patient. LPN 1 indicated the patient was involved in a severe motor vehicle accident (MVA) many years ago, which resulted in a traumatic brain injury (TBI) and seizures, received supplemental g-tube feedings 4 times daily, the patient was able to eat a soft diet (soft in texture, minimal chewing needed, easy to swallow), followed commands, and she cared for this patient 10 hours daily, 5 days per week. Clinical record for patient #1 was completed on 6/13/2022, start of care date 2/09/2022. A comprehensive assessment document dated 2/09/2022, titled OASIS ASSESSMENT DETAILS was completed by the agency s clinical manager (a RN). The document indicated the patient experienced pain, and reasons for hospitalization included pain management, but failed to include a comprehensive pain assessment was completed; and failed to indicate the patient s lung sounds, bowel sounds, last bowel movement, g-tube assessment (or presence of), diet, nutrition/hydration status, psychological/behavioral status, neurological status, mental status, functional limitations, musculoskeletal status, fall risk assessment, activities permitted, or equipment/supply needs were assessed by the RN. During an interview on 6/13/2022 at 12:49 PM, when queried to describe the patient s nutritional requirements, the clinical manager stated, Through her tube [g-tube]. When queried if the patient received any other route (oral) of nutrition, the clinical manager stated No. When queried to describe what she did during the comprehensive visit on 2/09/2022,		1. Every second calendar month beginning with startof care (within last five (5) days of the episode, including day sixty (60).This will occur unless there is a client elected transfer, a significant changein condition or discharge and return to the same agency during the 60-dayepisode. 2. Within forty-eight (48) hours of (or knowledge of) client return home from hospitaladmission of more than twenty-four (24) hours for any reason other thandiagnostic testing. Assessment may be done based on physician orderedresumption date. 3. Within forty-eight (48) hours of (or knowledgeof) discharge or transfer. 4. As indicated to create new HIPPS code beforebeginning a second 30-day payment period. Significant change in condition ornew diagnosis. PURPOSE	

	the clinical manager stated, I do the OASIS part, check her meds, or anything that was different, then we generate the POC [plan of care]. When queried if the comprehensive document should be fully completed by the RN, the clinical manager stated Yes. When queried why she didn t assess vital signs, the clinical manager indicated the LPN (LPN 1) was there too, so she put it down . When queried why a comprehensive pain assessment wasn t completed (history of hospitalization for pain management and pain was identified during the assessment), the clinical manager indicated the patient hasn t been in the hospital for pain management, and when queried, she indicated the comprehensive assessment document may be incorrect. When queried why she didn t assess lung sounds, she stated, I m not sure. When queried why she didn t assess the patient s last bowel movement, she stated, I don t know . When queried why she didn t assess the patient s musculoskeletal status, she stated Because she can t walk. When queried if equipment/supplies should be assessed during the comprehensive assessment, she stated, Yes. During an interview on 6/13/2022 at 2:13 PM, when queried what a comprehensive assessment consisted of, the clinical manager stated "My head is swimming ....", and no further information was provided. During an interview on 6/13/2022 at 3:14 PM, when queried what a comprehensive assessment consisted of, the alternate administrator (not an RN) indicated it consisted of the OASIS (OASIS tool does not include the physical assessment portion of a comprehensive assessment). The alternate administrator then handed the clinical manager a paper copy of the patient's comprehensive assessment (2/09/2022). The clinical manager was then queried, "When you do a comprehensive assessment, what does that consist of?" The clinical manager replied "Vitals." When queried if she was able to answer without looking at the document, the clinical manager stated "Probably not ... we have an order from the MD, then we take vital signs ...." When queried why she didn t		To identify decline or improvement in health status, modifythe plan of care and document changes that may affect care and reimbursement. To verify appropriate use of home care services anddetermine eligibility for Medicare benefit as applicable. To identify progress toward goals and effectiveness ofinterventions. SPECIAL INSTRUCTION changes the plan care 1. Clients are reassessed to determine theirresponse to care. 2. Clients are reassessed when significant changesoccur in their condition. 3. Clients are reassessed when significant change occurin their diagnosis. 4. Reassessments are done when significant changesoccur in the environment or support system that affect the plan of care. 5. Each professional	

	document about the g-tube, the clinical manager stated, "Well it was clean, and it was patent." When queried how she knew it was patent, the clinical manager stated "When we are pushing something in there." When queried if she administered anything into the g-tube during her assessment, she stated "No, the LPN [LPN 1] was there and she had done that already." When queried if she knew the size of the g-tube, she indicated she wasn't sure. When queried if this information should be included in the comprehensive assessment, she stated. "Yes."		discipline will be responsiblefor reassessing care/service at least every fifty-six to sixty (56-60) dayswhile the client is receiving skilledservices. A marked improvement or worsening of a client's condition, whichchanges the plan of care needed and was not anticipated in the plan of care,would be considered a significant change. 6. The REGISTERED NURSE/therapist is responsiblefor reassessing the need for Home Health Aide services. Healthmasters reviewed 100% of all active clinical records (accountsfor seven (7) patients) for this deficient practice. All our patients assessmentswere completed and signed by our Two(2) RN nurses. Only our RN nurses have the expertise and knowledge to completean Oasis assessment. We will review all future Oasis assessments completed toassure that they are completed by, and signed off by one of our two (2) RN Nurses.	

			The Administrator will review and monitor alloasis assessments for staff completing and signing off on assessments. on-going policy	
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 registered nurse (RN) failed to ensure the patient s medication list was current, reviewed at least every 60 days, included all medications the patient used, the route, the dose, and/or the indications for use; and/or failed to ensure a drug regimen review was completed to identify duplicate drug therapy, for 6 of 7 clinical records reviewed (#1, 2, 3, 4, 5, 6,).	G0536	Healthmasters has a small patient census, this allowed theagency to discharge and complete a start of care on the same day. Each of ourpatients will be discharged and re-admitted on same day basis, allowing theagency to bring current oasis into compliance. The agency will now put updated policy into place to ensure that our oasis remains in compliance:	2022-08-31

Findings include:

1. An undated agency policy received on 6/09/2022, titled Medication Profile stated ... The medication Profile must include at least the following ... Current medications ... Dose ... Route ... Frequency ... Drug Classification [indication for use] ... Nursing ... check all medications ... to identify ... duplicate drug therapy ... The medication profile will be updated at least every 60 days ....

2. An undated agency policy received on 6/09/2022 titled Comprehensive Assessment of Patients (OASIS) [outcome assessment and information set] stated ... A comprehensive assessment ... will be performed ... no earlier than five days prior to the last day of the certification period ... between and including days 56-60 ... Components of a comprehensive assessment includes ... Review of medications ....

3. Observation of a home visit occurred on 6/09/2022 at 1:00 PM, with patient #1 and licensed practical nurse (LPN) 1. A list of the patient s current medications was posted on the inside of a cabinet. The list revealed the patient took valproic acid (anti-seizure medication), Olly sleep gummy (sleep aid), and CBD oil (cannabidiol, a derivative of cannabis). During this visit, the patient s plan of care for certification period 4/10/2022 6/08/2022, was reviewed and failed to include these medications.

Clinical record for patient #1 was completed on 6/13/2022, start of care date 2/09/2022. A document titled Home Health Plan of Care & Certification for certification period 4/10/2022 6/08/2022 included a section titled Medications . The list failed to include any indications for use, for neither scheduled nor PRN (as needed) medications; medication tablets ordered to be administered via g-tube (a tube inserted directly into the stomach for administration of nutrition/hydration and /or medications) failed to indicate if the

Healthmasters is hiring anotherRN, Who has twenty years of home healthcare experience.

The RN will focus on, Oasis,plans of care, patient medications, contact with physicians and supervisoryvisits. The RN will complete PRN visits as needed.

This increase in medical staff will allow the agency tocomplete its comprehensive re-assessment with in the required every 56-60 days.

Policy: updated 08-05-2022

Healthmasters will reconcile all medications taken by theclient prior to admission to home care with those ordered at the time of admission,before and after inpatient facility stays, at 60-day reassessment visits, andat the time of discharge.

PURPOSE

To prevent potential medicationerrors and to assure clients are receiving all prescribed and necessarymedications.

	medication should be crushed; multivitamin oral liquid was listed twice; tylenol (acetaminophen, pain relief, fever reducer) was duplicated 5 times: ... Tylenol for Children + Adults Oral Suspension 160 MG/5ML - Every 6 hours PRN [no indication for use] - One tsp - G-Tube ... Tylenol Extra Strength Oral Solution 160 MG/5ML ml [no dose or frequency] - G-Tube ... Tylenol (160 mg/mL Elix - Every 4 Hours PRN [no dose or indication for use] ... Tylenol - PRN - 1 Tab [no dose or indication for use] Feeding Tube ... Tylenol Extra Strength Oral Solution 160 MG/5ML - PRN [no dose or indication] PEG TUBE .... ; Excedrin (acetaminophen, aspirin and caffeine) Migraine was duplicated twice: ... Excedrin Migraine Oral Tablet 250-250-65 MG - Every 6 hours - Tab(s) 1 ... Excedrin Migraine Oral Tablet 250-250-65 MG - PRN - Tab(s) [no dose or indication] - Feeding Tube .... During an interview on 6/13/2022 at 1:24 PM, when queried if medications should include indications for use, the clinical manager indicated they should. When queried what medication orders should include, the clinical manager indicated they should include the name of the drug and the reason. When queried if directions for use should include if the medication should be crushed, the clinical manager stated, Yes. During an interview on 6/13/2022 at 1:51 PM, when queried on the last time an RN saw the patient, the alternate administrator indicated the patient was seen in April (2022). When queried who did the comprehensive re-assessment (with medication review) that was due between 6/3/2022 6/08/2022, the alternate administrator indicated no visit was made (as of 6/13/2022). When queried how she performed a drug regimen review (DRR), the clinical manager indicated she looked at the patient s medications, the patient previously saw her physician, so he ordered it. 4. Clinical record review for patient #2 was completed on 6/13/2022 (start of care date 2/23/2013). The electronic medical record		Medications: include all over the counter, prescription, regularlytaken PRN medications, herbals and nutraceuticals that the client takes in allplaces of residence. SPECIAL INSTRUCTIONS 1. At the time of admission to home care agency,the admitting professional will document a complete list of medications takenby the client prior to admission. This will include all over the counter,prescribed, and PRN medications. Documentation of these medications will be listedon the Medication profile and include name, dose, route of administration, frequencyand when last dose was taken. 2. The information will be obtained from the clientif possible. If the client is unable to communicate this information, it may beobtained from family members, medication bottle labels, client's pharmacy orfrom an inpatient facility if recently discharged. 3. The admission professional will review thismedication list with the	

	(EMR) failed to evidence any non-skilled nursing assessments were made, and the last OASIS/Non-OASIS re-assessment was completed 11/20/2020. The record failed to evidence the patient s medication list was current, and was reviewed at least every 60 days. During an interview on 6/13/2022 at 3:25 PM, when queried when the last time an RN saw this patient (#2), the clinical manager stated, I m not sure. When queried if an RN completed a comprehensive re-assessment after 11/20/2020, the alternate administrator stated, ... No, I don t see any ... No, there s none. 5. Clinical record review for patient #3, a HHA [home health aide] only patient, was completed on 6/13/2022 (start of care date 4/22/2013). The EMR evidenced the last comprehensive re-assessment was completed 7/11/2020. The record failed to evidence the patient s medication list was current, and was reviewed at least every 60 days. During an interview on 6/13/2022 at 3:43 PM, when queried if she remembered the last time she saw this patient (#3), the clinical manager stated, No. When queried if any comprehensive re-assessments were completed after 7/11/2020, the alternate administrator stated, No. 6. Clinical record review for patient #4 was completed on 6/13/2022 (start of care date 4/08/2008). The EMR evidenced the last comprehensive re-assessment was completed 1/25/2022, and the last routine skilled nursing visit was 1/29/2021. The record failed to evidence the patient s medication list was current, and was reviewed at least every 60 days. During an interview on 6/13/2022 at 3:57 PM, when queried when she last saw the patient, the clinical manager stated, Maybe a month ...		non-physician practitioner (NPP) andconfirm those medications that are to be continued or discontinued. The doseswill be confirmed with the physician/allowed non-physician practitioner (NPP)and changes will be noted in the record and on the plan of care. 4. If the client continues to receive home careafter 60 days, the clinician doing the reassessment will again review allmedications client is taking, update the record and the client plan of care. 5. If the client is admitted to an inpatientsetting while receiving home care services, a list of current medications willbe sent to the admitting facility. 6. When client is discharged from the facility, themedications will be reviewed, and the orders updated to reflect changes and/orcontinuation of previous orders. 7. When the client is discharged from home careservices, a current list of medications will be reviewed with the client	

	2 months .... , and the alternate administrator stated, Maybe a month, 2 months .... When queried if a comprehensive re-assessment was completed after 1/25/2022, the alternate administrator stated, No .... , and indicated the patient was only seen by a HHA now. 7. Clinical record review for patient #5 was completed on 6/13/2022 (start of care date 3/18/2017). The EMR evidenced the last comprehensive re-assessment was completed 2/20/2022, and no other skilled nursing visits were completed on or after 2/20/2022. The record failed to evidence the patient s medication list was current, and was reviewed at least every 60 days. During an interview on 6/13/2022 at 3:53 PM, when queried when she last saw the patient, the clinical manager stated, I can t remember. When queried if an RN completed a comprehensive re-assessment after 2/20/2022, the alternate administrator stated, No. 8. Clinical record review for patient #6 was completed on 6/13/2022 (start of care date 12/08/2016). The EMR evidenced the last comprehensive re-assessment was completed 7/15/2021, and no other skilled nursing visits were completed on or after 7/15/2021. The record failed to evidence the patient s medication list was current, and was reviewed at least every 60 days. During an interview on 6/13/2022 at 3:47 PM, when queried when she last saw the patient, the clinical manager stated, I don t remember. When queried if an RN completed a comprehensive re-assessment after 7/15/2021, the alternate administrator stated, No. 9. During an interview on 6/6/2022 at 11:55 AM, when queried the process staff followed if the patient reported a new medication, or a new medication was observed in the home, the clinical manager indicated they would add		andphysician/allowed non-physician practitioner (NPP) and given to the client. 8. If the discharge is to a facility setting, thelist of currently prescribed medications and other medications the clientcurrently takes, will be sent to the admitting facility 9. Medications will be reviewed with the client oneach home visit to determine if other prescription or non-prescriptions drugsare being taken. Healthmasters has seven (7) clients at this time, a 100% of all clinical records were reviewed for this deficient practice. All medicationlistings for our clients were reviewed and updated with client physicians/allowed non-physician practitioner (NPP). This updated policy has been reviewed with all of our RNnurses, and we will continue to inservice this policy. Administrator will monitor on-going	

	the medication to the medication profile. When queried on the agency s process for a drug regimen review, the clinical manager indicated they checked any changes with the doctor. 410 IAC 17-14-1(a)(1)(B)			
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 (iii) Discharge and return to the same HHA during the 60-day episode. Based on record review and interview, the agency failed to ensure the registered nurse (RN) completed multiple comprehensive re-assessments within the last 5 days of every 60 days beginning with the start-of-care date for 6 of 6 clinical records reviewed which required comprehensive reassessments (#1, 2, 3, 4, 5, 6). Findings include:	G0546	Healthmasters has a low patient census this allowed us to discharge and re-admitted our patients on the same day, generating a new start of care, new plan of care generated from the oasis. All patients were discharged and re-admitted on different days to accommodate their physicians Schedule. This allowed healthmasters to start patients with new compliant start of care dates. Healthmasters will hire a RN with Twenty years of home health care experience ,RN will be assigned to review and approve oasis timely completion, accurate completion, care plans, patient medication updates, physician contact, supervisory visits, and PRN visits. Our low census will assist our New RN to complete Oasis, start of care timely, with initial assessment requirements. Our RN will be part of Nursing staff to assist with our Oasis, plans of care, which includes the Administrator, and RN supervisor. The process will include, over see for timely completion, check for accuracy of oasis, plans of care, medication checks, supervisory visits, and communications with the Physicians. Documentation of all Oasis, plans of care, contact with patients Physicians, and supervisory visits will be documented in newly formed review report form, which will be submitted to Broad of Directors for review. all procedures will strictly adhere to updated policy: 08-10- 2022 CLIENT	2022-08-12

	1. An undated agency policy received on 6/13/2022 titled Timeliness and Accuracy of Entries in the Clinical Record stated ... To ensure that a current and accurate clinical record exists for each patient ... All clinicians [includes RN] have a professional and legal duty of care ... record keeping should be able to evidence ... Full account of the assessment ... Relevant information about the condition of the patient at any given time ... Complete clinical progress notes on the date service is rendered .... 2. An undated agency policy received on 6/09/2022 titled Comprehensive Assessment of Patients (OASIS) [outcome assessment and information set] stated ... A comprehensive assessment ... will be performed ... not less frequently than every second month ...." 3. Clinical record for patient #1 was completed on 6/13/2022, start of care date 2/09/2022. The clinical record failed to evidence a comprehensive reassessment was completed for certification period that began on 6/09/2022. During an interview on 6/13/2022 at 1:51 PM, when queried on the last time an RN saw the patient, the clinical manager indicated it was her, and asked the alternate administrator, Didn t they leave and go back to Mexico? The alternate administrator indicated the patient was seen in April (2022). When queried who did the comprehensive re-assessment that was due between 6/3/2022 6/08/2022, the alternate administrator indicated no visit was made (as of 6/13/2022). During an interview on 06/09/2022 at 12:34 PM, when the surveyor queried why the EMR (electronic medical record) didn t evidence a current plan of care for the certification period that began 6/09/2022, the alternate administrator indicated it should be in there (the EMR), and stated This is unacceptable here. At 12:38 PM, the alternate administrator		COMPREHENSIVE ASSESSMENT Policy: updated 08-10-2022 The Comprehensive Assessment will be updated and revised asoften as the Client's condition warrants due to major decline or improvement inhealth status. Assessment will include OASIS data collection for allMedicare and Medicaid skilled clients. Clients who are not receiving skilledservices under the Medicare or Medicaid program will be assessed using the OASIStool or an alternative form identified by the agency. Reassessments MUST BEDONE AT LEAST: · Every second calendar month beginning with startof care (within last five (5) days of the episode, including day sixty (60).This will occur unless there is a client elected transfer, a significant changein condition or discharge and return to the agency during the 60-day episode. · Within forty-eight (48) hours of (or Knowledgeof) client return home from hospital admission of more than twenty-four (24) hoursfor any	

	generated .... When queried what generate meant, the alternate administrator stated, Complete it. When queried how that process worked, the alternate administrator stated, Let s go into OASIS assessment [in the EMR] ... I need to generate a [sic] OASIS assessment ... because the POC [plan of care] is gonna [sic] come off of the OASIS. We ll have to do that. The alternate administrator is not an RN. 4. Clinical record review for patient #2, a HHA only patient, was completed on 6/13/2022 (start of care date 2/23/2013). An electronic medical record (EMR) document titled Home Health Plan of Care & Certification for certification period 7/16/2020 to 9/13/2020 indicated the patient received HHA services 3 times per week for 1-24 hours each visit, to help with personal care, and skilled nursing to assess and evaluate HHA supervision and OASIS assessments (comprehensive assessments). The EMR also evidenced no non-skilled assessments were completed, and the last OASIS/Non-OASIS re-assessment was completed 11/20/2020. During an interview on 6/13/2022 at 3:25 PM, when queried when the last time an RN saw this patient (#2), the clinical manager stated, I m not sure. When queried if an RN completed a comprehensive re-assessment after 11/20/2020, the alternate administrator stated, ... No, I don t see any ... No, there s none. 5. Clinical record review for patient #3, a HHA only patient, was completed on 6/13/2022 (start of care date 4/22/2013). An EMR document titled Home Health Plan of Care & Certification for certification period 3/16/2020 to 5/14/2020 indicated the patient received HHA services 3 times per week for 1-24 hours each visit, to help with personal/household care; and skilled nursing to assess and evaluate HHA performance and patient comprehensive assessments. The EMR also evidenced the last comprehensive re-assessment was completed 7/11/2020.		reason other than diagnostic testing. Assessment may be done based onphysician ordered resumption date. · Within forty-eight (48) hours of (or knowledgeof) discharge or transfer. · AS indicated to create new HIPPS CODE beforebeginning a second 30-day payment period. Significant change in condition ornew diagnosis. PURPOSE To identify decline or improvement in health status, modifythe plan of care and document changes that may affect care and reimbursement. To verify appropriate use of home care services anddetermine eligibility for Medicare benefit as applicable. To identify progress toward goals and effectiveness ofinterventions. SPECIAL INSTRUCTION	

	During an interview on 6/13/2022 at 3:43 PM, during EMR review, when queried if she remembered the last time she saw this patient (#3), the clinical manager stated, No. When queried if any comprehensive re-assessments were completed after 7/11/2020, the alternate administrator stated, No. 6. Clinical record review for patient #4, a HHA only patient, was completed on 6/13/2022 (start of care date 4/08/2008). An EMR document titled Home Health Plan of Care & Certification for certification period 3/26/2022 to 5/24/2022 indicated the patient received HHA services 8 hours per day (not specified how many days per week); and skilled nursing every 4 weeks for vitamin B12 injections and lab draws. The EMR also evidenced the last comprehensive re-assessment was completed 1/25/2022, and the last routine skilled nursing visit was 1/29/2021. During an interview on 6/13/2022 at 3:57 PM, when queried who performed the blood draws on this patient (#4), the clinical manager indicated she did, but now the hospital does because she injured her right (dominant) arm the last time she saw this patient. When queried when she last saw the patient, the clinical manager stated, Maybe a month ... 2 months .... , and the alternate administrator stated, Maybe a month, 2 months .... When queried if a comprehensive re-assessment was completed after 1/25/2022, the alternate administrator stated, No .... , and indicated the patient was only seen by a HHA now. 7. Clinical record review for patient #5, a HHA only patient, was completed on 6/13/2022 (start of care date 3/18/2017). An EMR document titled Home Health Plan of Care & Certification for certification period 2/20/2022 to 4/20/2022 indicated the patient received HHA services 6 hours per day, 7 days per week); and skilled nursing every 30 days (not further specified), and every 56-60 days (not further specified). The EMR also evidenced the last comprehensive re-assessment was completed 2/20/2022, and no other skilled		· Clients are reassessed to determine theirresponse to care. · Clients are reassessed when significant changesoccur in their condition. · Clients are reassessed when significant changesoccur in their diagnosis. · Reassessments are done when significant changes occurin the clients environment or support system that affect the PLAN OF CARE. · Each professional discipline will be responsiblefor reassessing care/services at least EVERY FIFTY-SIX TO SIXTY (56-60) DAYSwhile the client is receiving skilled services. A marked improvement orworsening of a client's condition, which changes the PLAN OF CARE needed andwas not anticipated in the plan of care, would be considered a significantchange. · The Registered Nuse/Therapist is responsible forreassessing the need for home	

	nursing visits were completed on or after 2/20/2022. During an interview on 6/13/2022 at 3:53 PM, when queried when she last saw the patient, the clinical manager stated, I can t remember. When queried if an RN completed a comprehensive re-assessment after 2/20/2022, the alternate administrator stated, No. 8. Clinical record review for patient #6, a HHA only patient, was completed on 6/13/2022 (start of care date 12/08/2016). An EMR document titled Home Health Plan of Care & Certification for certification period 3/17/2021 to 5/15/2021indicated the patient received HHA services 6 hours per day (2 hours in the morning, and 6 hours in the evening), 5 days per week); and skilled nursing every 30 days (not further specified), and every 56-60 days to assess and evaluate. The EMR also evidenced the last comprehensive re-assessment was completed 7/15/2021, and no other skilled nursing visits were completed on or after 7/15/2021. During an interview on 6/13/2022 at 3:47 PM, when queried when she last saw the patient, the clinical manager stated, I don t remember. When queried if an RN completed a comprehensive re-assessment after 7/15/2021, the alternate administrator stated, No. 410 IAC 17-14-1(a)(1)(B)		· health aide services. · Special attention will be paid toclients-centered goal setting, clarifying the client's personal goals andhis/her expectations of the home care services. This will include evaluatingprocess used and effectiveness of plan established previously. · The assessment will identify the problems,needs, and strengths of the client and the care the family can provide. Theinitial and ongoing assessment includes consideration of the following. 1. Specific individualized client needs pertinentto the care or service being provided. 2. Description of any applicable strength theclient has including physical, psychosocial, and or spiritual resources thatincrease their ability to respond effectively to treatment and the ability tolearn. 3. Involvement of family friends, and otherindividuals or organizations. 4. Appropriateness of the	

			level of care provided bythe family or support system to safely meet the client needs. 5. Condition of the home and surroundingenvironment and identified safety needs within the home setting. 6. Progress toward goals since previous assessmentand clarify the problems that require continuing home care services. 7. Need for continuing home care services. 8. Ability/willingness of the client/family toassume responsibility for healthcare needs. · Revisions to the PLAN OF CARE must be communicatedas follows: 1. Any revision to the PLAN OF CARE due to a changein client health status MUST BE COMMUNICATED to client. Representative (if any), caregiver, and all physicians and allowed practitioners issuing orders forthe agency PLAN OF CARE. 2. Any revisions related to	

			MUST BE communicated to the client, representative, caregiver, allphysicians or allowed practitioners issuing order for the PLAN OF CARE, and the client'sprimary care practitioners issuing orders for the PLAN OF CARE, and the client'sprimary care practitioner or other health care professionals who will beresponsible for providing care and services to the client after discharge fromthe agency. · Client needs and the availability and adequacyof family and support systems will be considered in the care planning process. · Interim assessments on skilled Medicare and Medicaidclients will be completed using an assessment tool that includes OASIS data elementsand other information necessary to evaluate client outcomes. · Information from the assessment and reports willbe used to identify opportunities to improve agency performance. · Reassessments are	

			onphysician orders, client conditions, and/or professional staff judgement. Administrator will be responsible for monitoring, and this will be on-going.	
G0560	Discharge Planning 484.58 Condition of Participation: Discharge planning. Based on record review and interview, the home health agency failed to develop and implement an effective discharge planning process, which included a process to assist patients (who would transfer to another home health agency, or discharged to a long-term inpatient setting) and their caregivers in selecting a post-acute care provider (see tag G562); and failed to send a discharge summary to the patient's physician upon discharge from home health services (see tag G564). This practice had the potential to affect all agency patients upon discharge. Findings include: The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR §484.58:	G0560	Healthmasters has updated its client discharge process,discharge planning is initiated for every home care client at the time of theclient's admission for home care. When clients are admitted for home healthservices, the expectation is that the client will be discharged to self -careor care of family when goals are met. Discharging a client to another provideris permitted under limited circumstances that are documented in the admissionnotices. PURPOSE: To facilitate the clint's discharge or transfer to anotherentity when circumstances exist that	2022-08-26

	Discharge Planning.		this is the best solution for the client. To ensure continuity of care, treatment and services whenneeded. To assure collaboration with the physician/allowed non-physicianpractitioner, client and/or representative,family and other disciplines inplanning for discharge from agency Alternate Administrator will be responsible ; policy will be on-going	
G0562	Discharge Planning 484.58(a) Standard: Discharge planning. An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. Based on record review and interview, the home health agency failed to develop and implement an effective discharge planning process, which included a process to assist patients (who would transfer to another home health agency, or discharged to a long-term inpatient setting) and their caregivers in selecting a post-acute care provider.	G0562	Healthmasters has updated its client discharge process,discharge planning is initiated for every home care client at the time of theclient's admission for home care. When clients are admitted for home healthservices, the expectation is that the client will be discharged to self -careor care of family when goals are met. Discharging a client to another provideris permitted under limited circumstances that are documented in the admissionnotices. PURPOSE: To facilitate the clint's discharge or transfer to anotherentity when circumstances exist that	2022-08-22

	Findings include: An undated agency policy titled "Discharge/Transfer from Service" stated, "A patient may be transferred if their service/care needs cannot be met ... The patient will be provided with the name ... and contact name at the referral organization ...." The policy failed to include how the agency would assist the patient/caregiver in selecting another home health agency or long term care facility, or what criteria would be used to assist with the selection. During an interview on 6/10/2022 at 11:00 AM, when queried about the agency s policy and procedure review/updates as part of governing body responsibilities, the alternate administrator indicated there was nothing since a few years ago, before COVID-19 started, they were very far behind, and they had nothing to submit.		this is the best solution for the client. To ensure continuity of care, treatment and services whenneeded. To assure collaboration with the physician/allowed non-physicianpractitioner, client and/or representative,family and other disciplines inplanning for discharge from agency alternate administrator will monitorths policy; policy will be on-going	
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the home health agency failed to send a discharge summary to the patient's physician upon discharge from home health services, for 1 of 1 discharged records reviewed (#7). Findings include:	G0564	CLIENT DISCHARGE PROCESS POLICY: updated 08-12-2022 Discharge planning is initiated for every home care clientat the time of the client’s admission for home care. When clients are admittedfor home care services, the expectation is the client will be- discharged toself-care or care family when goals are met. Discharging a client to anotherprovider is permitted under limited circumstances that are documented in theadmission notices.	2022-08-22

	An undated agency policy titled "Discharge/Transfer from Service" stated, "... A completed discharge ... summary is sent to the primary care practitioner ... At determination to discharge ... Physician is to be notified that a copy of the written discharge summary is available upon request ...Discharge summary is written and in the chart ...." Clinical record review for patient #7 was completed on 6/13/2022. The electronic medical record (EMR) indicated the patient was discharged from services 4/30/2020, re-admitted 11/5/2021, recertified for services on 1/22/2022, and re-admitted again on 5/20/2022. The record failed to include a discharge summary between the dates of 1/2/2022 and 5/20/2022. During an interview on 6/13/2022 at 4:00 PM, when queried on the patient s discharge date (prior to the 5/20/2022 re-admission), the alternate administrator indicated he wasn t sure. When queried if the discharge summary was located in the EMR [electronic medical record], or if it was sent to the physician, the alternate administrator indicated that paperwork was on a computer disk at home. No further information was provided.		PURPOSE To facilitate the client's discharge or transfer to anotherentity when circumstances exist that this is the best solution for the client. To ensure continuity of care, treatment and services whenneeded. To assure collaboration with the physician/ allowednon-physician (NPP) ,client and/or representative, family and other disciplinesin planning for discharge from the agency. SPECIAL INSTRUCTIONS Discharge Procedure: 1. Planning for discharge is provided as part ofthe ongoing assessment of needs and in accordance with expected care outcomes.The client/family and/or client representative will participate in this processbeginning with the initial assessment visit. 2. Client's needs for continuing care to meetphysical and psychological needs are identified and clients are	

			informed in atimely manner (no less than fifteen days advance notice), of the need to planfor discharge or transfer to another level of care/organization. Clients areinformed of the reason for discharge and anticipated needs for service afterdischarge. 3. The physician/allowed non-physician practitioner(NPP) will be involved in the discharge plan and specific ongoing care needs willbe identified and addressed as part of the plan. 4. The impending discharge will be reviewed withother members of the home care team to assure coordination and continuity withthe client and family/caregivers. 5. The Registered Nurse or Therapist shall reviewthe clinical record to assure accuracy and completion. A Discharge plan shallbe developed that is documented in writing and includes all written/verbalinstruction regarding the client's ongoing care needs and available resources providedto the client and family	

			This policy has been updated and put into effect, to documentand ensure that patients are given at least a fifteen-day discharge notice. The policy will be monitored through our to DischargeProcedure, which will involve physicians, members of home care team/family/caregivers.Registered Nurses will review the clinical records to assure accuracy and completeness. This policy will be monitored by the Administrator; policyis on-going	
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	G0570	Healthmasters has a low patient census this allowed us todischarge and re-admitted our patients on the same day, generating a new startof care, new plan of care generated from the oasis. All patients weredischarged and re-admitted on different days to accommodate their physiciansSchedule. This allowed healthmasters to start	2022-08-26

	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 observation, record review, and interview, the home health agency failed to ensure the patient's plan of care was established, periodically reviewed (at least every 60 days), and signed by the certifying physician, and failed to ensure the patient received the skilled nursing services as ordered in the patient's most recent plan of care (see tag G572); the patient's plan of care failed to include all pertinent diagnoses, the types of services, supplies, and equipment required, the frequency and duration of visits to be made, functional limitations, activities permitted, nutritional requirements, all medications and treatments, safety measures to protect against injury, a description of the patient s risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors, patient and caregiver education and training, patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient, or the patient's allergies (see tag G574); all patient care orders were recorded in the plan of care (see tag G576); the registered nurse (RN) failed to conform with the physician's orders as noted on the plan of care (see tag G578); Drugs, services, and/or treatments were administered only as ordered by a physician (see tag G580); the plan of care was reviewed and revised by the certifying physician no less frequently than once every 60 days (see tag G588); all patients received a home visit schedule (see tag G614); all patients received a list of medications, including which medications the agency staff administered (see tag G616); any treatments administered by agency staff (see tag G618); or the name and contact information for the agency s clinical manager (see tag G622).		patients with new compliant start ofcare dates. Healthmasters has hired a RN assist with oasis and care plans. Healthmasters hired RN has Twenty years of home health careexperience,RN will be assigned to review and approve oasis timely completion,accurate completion, care plans, patient medication updates, physician contact,supervisory visits, and PRN visits. Our low census will assist our New hired RNto complete Oasis, start of care timely, with initial assessment requirements.Our new hired RN will be part of Nursing staff to assist with our Oasis, plansof care, and newly formed review process, which includes the Administrator, andRN. The process will include, over- see for timely completion, check for accuracyof oasis, plans of care, medication checks, supervisory visits, andcommunications with the Physicians. Documentation of all Oasis, plans of care, contact withpatients Physicians, and supervisory visits will be documented in newly formed	

	The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR §484.60 Care planning, coordination, quality of care. A standard citation was also evidenced at this level as follows: Based on record review and interview, the home health agency failed to ensure all patients had a current plan of care for 7 of 7 records reviewed (#1, 2, 3, 4, 5, 6, 7). Findings include: 1. During an interview on 6/6/2022 at 11:55 AM, when queried if the agency maintained electronic medical records (EMRs), paper records, or both, the alternate administrator indicated all clinical records were maintained in the EMR, and nothing was on paper. When queried the timeframe for clinicians to submit documentation following a home visit, the clinical manager indicated all documentation was submitted while at the patient s home (electronically). When queried the timeframe for documents to be incorporated into the patient s clinical record, the clinical manager stated Immediately. 2. An undated agency policy titled Physician Orders/Plan of Care stated ... Purpose: ... To ensure that each patients care is under the direction of the physician ... The plan [of care] is ... maintained as a part of the ... clinical record ... includes ... diagnosis, prognosis, medications ... treatments, diets, goals to be accomplished ... and equipment ... will be specific to the patient ... Orders for all disciplines shall include amount, frequency,		submitted to Broad of Directors for review. Administrator will beresponsible for monitoring, and this will be on-going.	

recertify the written plan of care at least once per episode [certification period] ....

3. Clinical record for patient #1 was completed on 6/13/2022 (start of care date 2/09/2022). The EMR failed to include a current plan of care for certification period 6/09/2022 8/07/2022.

During an interview on 6/09/2022 at 12:34 PM, when queried if the patient s EMR included a plan of care for certification period 6/092022 8/07/2022, the alternate administrator indicated it did not.

During an interview on 6/13/2022 at 1:51 PM, when queried (at a later date) if there was a current plan of care for certification period 6/092022 8/07/2022, the alternate administrator stated, No.

4. Clinical record review for patient #2 was completed on 6/13/2022 (start of care date 2/23/2013). The EMR evidenced the most recent plan of care was for certification period 1/18/2020 3/17/2020.

During an interview on 06/09/2022 at 12:32 PM, when queried why the EMR didn t include a plan of care any time after 2020, the alternate administrator stated, We may have missed that ....

During an interview on 6/13/2022 at 3:25 PM, when queried if the EMR included a completed plan of care any time after 3/17/2020, the alternate administrator indicated there was not.

5. Clinical record review for patient #3 was completed on 6/13/2022 (start of care date 4/22/2013). The EMR evidenced the most

	3/16/2020 5/14/2020. During an interview on 06/09/2022 at 12:32 PM, when queried why the EMR didn t include a plan of care any time after 2020, the alternate administrator indicated this patient hasn t had one either, since 2020. During an interview on 6/13/2022 at 3:43 PM, when queried if the EMR included a completed plan of care any time after 5/14/2020, the alternate administrator indicated there was not. 6. Clinical record review for patient #4 was completed on 6/13/2022 (start of care date 4/08/2008). The EMR evidenced the most recent plan of care was for certification period 3/26/2022 5/24/2022. During an interview on 06/09/2022 at 12:43 PM, when queried to confirm there was no plan of care in the EMR after certification period ending 5/24/2022, the alternate administrator indicated there was not. During an interview on 6/13/2022 at 3:57 PM, when queried if the EMR included a completed plan of care any time after 5/22/2022, the alternate administrator indicated there was not. Clinical record review for patient #5 was completed on 6/13/2022 (start of care date 3/18/2017). The EMR evidenced the most recent plan of care was for certification period 2/20/2022 4/20/2022. During an interview on 06/09/2022 at 12:42 PM, the alternate administrator was queried if there was a care plan after certification period ending 4/2022, to which he stated, Ok I see that ... Okay so you re going to have us busy			

During an interview on 6/13/2022 at 3:50 PM, when queried if the EMR included a completed plan of care any time after 4/20/2022, the alternate administrator indicated there was not.

7. Clinical record review for patient #6 was completed on 6/13/2022 (start of care date 12/08/2016). The EMR evidenced the most recent plan of care was for certification period 3/17/2021 5/15/2021.

During an interview on 06/09/2022 at 12:40 PM, when queried why the patient had no plan of care after 5/2021, the alternate administrator indicated the patient didn t, and they would have to generate one for her as well.

During an interview on 6/13/2022 at 3:47 PM, when queried to confirm there was no plan of care after the certification period ending 5/15/2021, the alternate administrator stated, That s correct.

8. Clinical record review for patient #7 was completed on 6/13/2022 (start of care date 5/20/2022). The most recent EMR document titled Home Health Plan of Care & Certification was for certification period 11/05/2021 to 1/03/2022, and indicated the start of care date as 5/22/2022. The EMR did not include a plan of care for the re-admission on 5/22/2022, for certification period 5/22/2022- 7/20/2022.

During an interview on 6/07/2022 at 11:57 AM, when queried who the discharged patient was, the alternate administrator and clinical manager indicated patient #7 was currently discharged, and was with family in Mexico.

During an interview on 6/10/2022 at 10:30 AM, when queried why the surveyor was told this

	patient was discharged, when the EMR included an admission document for 5/22/2022, and current daily skilled visit notes, to which the alternate administrator stated, ... Oh, I didn t realize ... I have to get back in the groove .... During an interview on 6/13/2022 at 4:00 PM, when queried when this patient was re-admitted, the alternate administrator indicated he was re-admitted about a week and a half ago, When queried if the EMR included a plan of care for this admission, the alternate administrator indicated there was not. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR §484.60: Care Planning, Coordination of Services, and Quality of Care. 410 IAC 17-13-1(a) 410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(C) 410 IAC 17-13-1(a)(1)(D)(i, ii, iii, vi, vii, viii, ix, x, xi, xiii) 410 IAC 17-14-1(a)(1)(H) 410 IAC 17-13-1(a)(2)			
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	G0572	Healthmasters is in the process of hiring a RN with Twenty years of home health careexperience, RN will be assigned to review and verify oasis timely completion,accurate	2022-08-10

	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 observation, record review, and interview, the home health agency failed to ensure the patient's plan of care was periodically reviewed (at least every 60 days); and failed to ensure the patient received the skilled nursing services as ordered in the patient's most recent plan of care for 7 of 7 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7). Findings include: 1. An undated agency policy received 6/09/2022, titled Physician Orders/Plan of Care stated ... Purpose: ... To ensure that each patients care is under the direction of the physician ... The physician establishes and reviews a plan of treatment [plan of care] ... The physician sets up a plan of care, which includes ... service ... treatments ... to be provided by the agency ... The physician ... will review and recertify the written plan of care at least once per episode [certification period/every 60 days] .... 2. Clinical record for patient #1 was completed on 6/13/2022 (start of care date 2/09/2022). The electronic medical record (EMR) evidenced a plan of care for certification period 4/10/2022 6/08/2022. As of 6/13/2022 (the 65th day), the patient s plan of care was not reviewed by the physician. During an interview on 6/13/2022 at 1:51 PM, when queried if there was a current plan of care, the alternate administrator stated, No.		completion, care plans, patient medication updates, physician contact,supervisory visits, and PRN visits. Our low census will assist in our efforts to complete Oasis, start of care timely, with initial assessment requirements.Our new RN will be part of Nursing staff to assist with our Oasis, plansof care, and newly formed review process, which includes the Administrator, andRN supervisor . The process will include, over- see for timely completion, check for accuracyof oasis, plans of care, medication checks, supervisory visits, andcommunications with the Physicians. our recently updated policy for : CLIENT REASSESSMENT/UPDATE OF COMPREHENSIVE ASSESSMENT Policy: updated 08-10-2022 The Comprehensive Assessment will be updated and revised asoften as the Client’s condition warrants due to major decline or improvement inhealth status. Assessment will include OASIS data collection for allMedicare and Medicaid skilled clients.	

	3. Clinical record review for patient #2 was completed on 6/13/2022 (start of care date 2/23/2013). The electronic medical record evidenced the most recent completed plan of care was for certification period 1/18/2020 3/17/2020. As of 6/13/2022 (the 877th day), the patient s plan of care was not reviewed by the physician. An electronic medical record document titled Home Health Plan of Care & Certification for certification period 7/16/2020 to 9/13/2020 (not signed by the registered nurse [RN] or physician) indicated orders for skilled nursing to assess and evaluate home health aide (HHA) supervision and OASIS (outcome assessment and information set) assessments (comprehensive assessments). The EMR, the last OASIS/Non-OASIS re-assessment was completed 11/20/2020. The agency failed to provide skilled nursing services as ordered on the plan of care. During an interview on 6/13/2022 at 3:25 PM, when queried when the last time an RN saw this patient (#2), the clinical manager stated, I m not sure. When queried if an RN completed a comprehensive re-assessment after 11/20/2020 (as ordered on the plan of care), the alternate administrator stated, ... No, I don t see any ... No, there s none. During an interview on 6/13/2022 at 3:25 PM, when queried if the EMR included a completed plan of care any time after 3/17/2020, the alternate administrator indicated there was not. 4. Clinical record review for patient #3 was completed on 6/13/2022 (start of care date 4/22/2013). The EMR evidenced the most recent plan of care was for certification period 3/16/2020 5/14/2020. As of 6/13/2022 (the 819th day), the patient s plan of care was not reviewed by the physician.		Clients who are not receiving skilledservices under the Medicare or Medicaid program will be assessed using the OASIStool or an alternative form identified by the agency. Reassessments MUST BEDONE AT LEAST: · Every second calendar month beginning with startof care (within last five (5) days of the episode, including day sixty (60).This will occur unless there is a client elected transfer, a significant changein condition or discharge and return to the agency during the 60-day episode. · Within forty-eight (48) hours of (or Knowledgeof) client return home from hospital admission of more than twenty-four (24) hoursfor any reason other than diagnostic testing. Assessment may be done based onphysician ordered resumption date. · Within forty-eight (48) hours of (or knowledgeof) discharge or transfer. · AS indicated to create new HIPPS CODE beforebeginning a second 30-day payment period.	

During an interview on 6/13/2022 at 3:43 PM, when queried if the EMR included a completed plan of care any time after 5/14/2020, the alternate administrator indicated there was not.

An EMR document titled Home Health Plan of Care & Certification for certification period 3/16/2020 5/14/2020 indicated skilled nursing orders for skilled nursing to perform patient comprehensive assessments (no frequency indicated). The EMR evidenced the last comprehensive re-assessment was completed 7/11/2020.

During an interview on 6/13/2022 at 3:43 PM, when queried if she remembered the last time she saw this patient (#3), the clinical manager stated, No. When queried if any comprehensive re-assessments were completed after 7/11/2020, the alternate administrator stated, No. The agency failed to provide skilled nursing services as ordered on the plan of care.

5. Clinical record review for patient #4 was completed on 6/13/2022 (start of care date 4/08/2008). The EMR evidenced the most recent plan of care was for certification period 3/26/2022 5/24/2022. As of 6/13/2022 (the 79th day), the patient s plan of care was not reviewed by the physician.

During an interview on 6/13/2022 at 3:57 PM, when queried if the EMR included a completed plan of care any time after 5/22/2022, the alternate administrator indicated there was not.

A document titled Home Health Plan of Care & Certification for certification period 3/26/2022 to 5/24/2022 indicated skilled nursing visits were ordered every 4 weeks for administration of B12 shots and lab draws for PT/INR (a blood test for therapeutic lab monitoring of a blood

ornew diagnosis.

PURPOSE

To identify decline or improvement in health status, modifythe plan of care and document changes that may affect care and reimbursement.

To verify appropriate use of home care services anddetermine eligibility for Medicare benefit as applicable.

To identify progress toward goals and effectiveness ofinterventions.

SPECIAL INSTRUCTION

· Clients are reassessed to determine theirresponse to care.

· Clients are reassessed when significant changesoccur in their condition.

· Clients are reassessed when significant changesoccur in their diagnosis.

· Reassessments are done when significant changes occurin the clients environment or support system that affect

	thinner). A home visit was conducted on 6/10/2022 at 9:25 AM, with home health aide (HHA) 1. When queried if she took blood thinners, the patient indicated she did. When queried who performed blood draws for therapeutic lab monitoring, she indicated she went to the hospital for the tests monthly. When queried if she received monthly B12 shots, and who administered them, the patient indicated she did get monthly B12 shots, and her sister administered them. During an interview on 6/13/2022 at 3:57 PM, when queried who performed monthly blood draws on the patient (#4), the clinical manager indicated she used to, but now the hospital does. When queried why, the clinical manager indicated she injured her right (dominant) arm and could no longer perform the blood draws. When queried if there was another agency nurse to perform the ordered lab draws, she indicated there was not. The agency failed to provide skilled nursing as ordered on the plan of care. 6. Clinical record review for patient #5 was completed on 6/13/2022 (start of care date 3/18/2017). The EMR evidenced the most recent plan of care was for certification period 2/20/2022 4/20/2022. As of 6/13/2022 (the 113th day), the patient s plan of care was not reviewed by the physician. During an interview on 6/13/2022 at 3:50 PM, when queried if the EMR included a completed plan of care any time after 4/20/2022, the alternate administrator indicated there was not. A document titled Home Health Plan of Care & Certification for certification period 2/20/2022 4/20/2022 indicated skilled nursing orders every 30 days for HHA supervision, and every 56-60 days for comprehensive assessments.		the PLAN OF CARE. · Each professional discipline will be responsiblefor reassessing care/services at least EVERY FIFTY-SIX TO SIXTY (56-60) DAYSwhile the client is receiving skilled services. A marked improvement orworsening of a client's condition, which changes the PLAN OF CARE needed andwas not anticipated in the plan of care, would be considered a significantchange. · The Registered Nuse/Therapist is responsible forreassessing the need for home · health aide services. · Special attention will be paid toclients-centered goal setting, clarifying the client's personal goals andhis/her expectations of the home care services. This will include evaluatingprocess used and effectiveness of plan established previously. · The assessment will identify the problems,needs, and strengths of the client and the care the family can provide.	

	The EMR indicated the last skilled nursing comprehensive visit was performed 2/20/2022, and no other nursing visits were made. The agency failed to provide skilled nursing services as ordered on the plan of care. During an interview on 6/13/2022 at 3:55 PM, when queried the last time she saw this patient (#5), the clinical manager indicated she didn t remember. 7. Clinical record review for patient #6 was completed on 6/13/2022 (start of care date 12/08/2016). The EMR evidenced the most recent plan of care was for certification period 3/17/2021 5/15/2021. As of 6/13/2022 (the 453rd day), the patient s plan of care was not reviewed by the physician. During an interview on 06/09/2022 at 12:40 PM, when queried why the patient had no plan of care after 5/2021, the alternate administrator indicated the patient didn t, and they would have to generate one for her as well. During an interview on 6/13/2022 at 3:47 PM, when queried to confirm there was no plan of care after the certification period ending 5/15/2021, the alternate administrator stated, That s correct. 8. Clinical record review for patient #7 was completed on 6/13/2022 (start of care date 5/20/2022). The most recent EMR document titled Home Health Plan of Care & Certification was for certification period 11/05/2021 to 1/03/2022, and indicated a start of care date of 5/20/2022. The EMR did not include a plan of care for the re-admission on 5/20/2022. As of 6/13/2022 (the 220th day), the patient s plan of care was not reviewed by the physician. During an interview on 6/10/2022 at 10:30 AM, when queried why the surveyor was previously		assessment includes consideration of the following. 1. Specific individualized client needs pertinentto the care or service being provided. 2. Description of any applicable strength theclient has including physical, psychosocial, and or spiritual resources thatincrease their ability to respond effectively to treatment and the ability tolearn. 3. Involvement of family friends, and otherindividuals or organizations. 4. Appropriateness of the level of care provided bythe family or support system to safely meet the client needs. 5. Condition of the home and surroundingenvironment and identified safety needs within the home setting. 6. Progress toward goals since previous assessmentand clarify the problems that require continuing home care services. 7. Need for continuing home care services. 8. Ability/willingness of the	

	told by the alternate administrator and clinical manager that this patient was discharged, but the EMR included an admission comprehensive assessment dated 5/20/2022, and current daily skilled visit notes, the alternate administrator stated, ... Oh, I didn t realize ... I have to get back in the groove .... During an interview on 6/13/2022 at 4:00 PM, when queried if the EMR included a plan of care for this admission (5/20/2022), the alternate administrator indicated there was not. 410 IAC 17-13-1(a)		client/family toassume responsibility for healthcare needs. · Revisions to the PLAN OF CARE must be communicatedas follows: 1. Any revision to the PLAN OF CARE due to a changein client health status MUST BE COMMUNICATED to client. Representative (if any), caregiver, and all physicians and allowed practitioners issuing orders forthe agency PLAN OF CARE. 2. Any revisions related to plans for the client'sdischarge MUST BE communicated to the client, representative, caregiver, allphysicians or allowed practitioners issuing order for the PLAN OF CARE, and the client'sprimary care practitioners issuing orders for the PLAN OF CARE, and the client'sprimary care practitioner or other health care professionals who will beresponsible for providing care and services to the client after discharge fromthe agency. · Client needs and the availability and adequacyof family and support systems will	

			be considered in the care planning process. · Interim assessments on skilled Medicare and Medicaidclients will be completed using an assessment tool that includes OASIS data elementsand other information necessary to evaluate client outcomes. · Information from the assessment and reports willbe used to identify opportunities to improve agency performance. · Reassessments are conducted every visit based onphysician orders, client conditions, and/or professional staff judgement. Documentation of all Oasis, plans of care, contact withpatients Physicians, and supervisory visits will be documented in newly formed reviewreport form, which will be submitted to Broad of Directors for review monthly. Administrator will	

			and this will be on-going.	
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge;	G0574	Healthmasters has a low patient census this allowed us todischarge and re-admitted our patients on the same day, generating a new startof care, new plan of care generated from the oasis. All patients weredischarged and re-admitted on different days to accommodate their physiciansSchedule. This allowed healthmasters to start patients with new compliant start ofcare dates. Healthmasters will hired a RN to assist with oasis and care plans, Medications ordered by the Clients Physcians. Healthmasters hired RN has Twenty years of home health careexperience, RN will be assigned to review and approve oasis timely completion,accurate completion, care plans, patient medication updates, physician contact,supervisory visits, and PRN visits. Our low census will	2022-08-10

	(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the patient's plan of care failed to include all pertinent diagnoses, the types of services, supplies, and equipment required, the frequency and duration of visits to be made, functional limitations, activities permitted, nutritional requirements, all medications and treatments, safety measures to protect against injury, a description of the patient s risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors, patient and caregiver education and training, patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient, or the patient's allergies, for 1 of 1 home visit observed with skilled nursing services (#1). Findings include: An undated agency policy received 6/09/2022, titled Physician Orders/Plan of Care stated ... Purpose: ... To ensure that each patients care is under the direction of the physician ... The plan [of care] is ... maintained as a part of the ... clinical record ... includes ... diagnosis, prognosis, medications ... treatments, diets, goals to be accomplished ... and equipment ... will be specific to the patient ... Orders for all disciplines shall include amount, frequency, and duration .... Observation of a home visit occurred on 6/09/2022 at 1:00 PM, with patient #1 and licensed practical nurse (LPN) 1. The patient presented up in a pressure relieving (tilting) wheelchair with head rest and wrap around leg rests, contractures to both hands, and wore ankle foot orthotics (AFOs) on both feet (braces to support feet due to foot drop/inability to hold feet up). Equipment		assist our New hired RNto complete Oasis, start of care timely, with initial assessment requirements.Our new hired RN will be part of Nursing staff to assist with our Oasis, plansof care, and newly formed review process, which includes the Administrator, andRN. The process will include, over- see for timely completion, check for accuracyof oasis, plans of care, medication checks, supervisory visits, andcommunications with the Physicians. we updated our plan of care policy so our intent of very clear: 08-10-2022 POLICY: Homecare services are furnished under the supervision anddirection of the client's physician/ allowed non-physician practitioner (NPP).The Plan of care is based on a comprehensive assessment and informationprovided by the client/ family and health team members. Planning for care is adynamic process that addresses the care, treatment and services to be provided.The plan will be consistently	

observed included a tilt table (used to facilitate weight bearing/leg muscle strengthening [a therapy modality]), incontinence pads and adult briefs, size 14 fr (french) straight catheter kits (used to obtain urine specimens for lab testing), and g-tube (a tube inserted into the stomach for administration of nutrition, fluids, and/or medications) supplies/dressings. Observed LPN 1 provide incontinence care, and care to the patient s g-tube insertion site (mic-key button- a special low-profile tube), which was cleansed, ointment applied, and dressed with gauze. During this time, LPN 1 was queried to describe the care she provided to the patient. LPN 1 indicated she administered supplemental g-tube feedings/hydration 4 times daily, administered medications via g-tube, fed the patient a soft diet (soft in texture, minimal chewing needed, easy to swallow), provided incontinence care, showered the patient twice weekly, performed g-tube care and dressing changes, got the patient up daily for 30 minutes on the tilt table to provide leg strengthening exercise, and she cared for this patient 10 hours daily, 5 days per week. When queried if she ever needed to intermittently catheterize the patient for signs/symptoms of urinary tract infection (UTI), LPN 1 indicated she did in February (2022), which resulted in the diagnosis of UTI and treatment with antibiotics. When queried to describe the patients health condition, LPN 1 indicated the patient was involved in a severe motor vehicle accident (MVA) many years ago, which resulted in a traumatic brain injury (TBI) and seizures, and followed commands.

A document received from person 3's office (patient #1's certifying physician) included a document dated 4/20/2022, titled "Office Visit". The document indicated past medical history/diagnoses included aphasia (inability to speak) due to TBI, hemiplegia (paralyzed on half of body) affecting dominant side, recurrent UTIs, incontinence of bowel and bladder, menopause, and urinary retention; allergies included clindamycin and keflex (both antibiotic medications), and keppra (anti-seizure medication).

Clinical record for patient #1 was completed

reviewed to ensure that client needs are met, andwill be updated as necessary, but at least every sixty (60) days.

In cases where client care is provided in a clinical settingwith rotating staff of physicians/ allowed non- physician practitioner (NPP),orders shall be processed in accordance with Agency policy and the agency shallaccept the signature and date of the physician / allowed non-physicianpractitioner assigned to the clinic at the time orders are presented forsignature as the attending physician / allowed non-physician practitioner forthe client.

PURPOSE:

To provide guidelines for agency staff to develop a plan ofcare individualized to meet specific identified needs.

To reflect client’s ability to make choices and activelyparticipate in establishing and following the plan designated to attainpersonal health goals.

To assure that the plan meets State/Federal guidelines, andall

	on 6/13/2022, start of care date 2/09/2022. A document titled Home Health Plan of Care & Certification for certification period 4/10/2022 6/08/2022, indicated the patient's equipment included oxygen, and risks for hospitalization included severe pain; and failed to include diagnoses of aphasia due to TBI, hemiplegia affecting dominant side, recurrent UTIs, incontinence of bowel and bladder, menopause, or urinary retention; allergies included clindamycin, keflex, and keppra; supplies and equipment included a pressure relieving (tilting) wheelchair with head rest and wrap around leg rests, AFOs, a tilt table, incontinence pads and adult briefs, size 14 fr (french) straight catheter kits, and g-tube size, supplies/dressings; orders included the frequency and duration of skilled nursing visits; functional limitations included contractures to both hands and bilateral foot drop; activities permitted included exercises prescribed - tilt table 30 minutes each visit for muscle strengthening/weight bearing; nutritional requirements included a soft diet, or specific orders for amount/frequency of supplemental nutritional/hydration feedings via g-tube; all orders for the skilled nurse, including administration of medications either orally or via g-tube, feed patient a soft diet, administer supplemental g-tube feedings/hydration, provide personal care, intermittent catheterization for signs/symptoms of UTI, perform leg strengthening exercises with use of a tilt table for 30 minutes daily, care for/treatment of g-tube insertion site, or application of AFOs; or any patient/caregiver education/training; patient specific interventions related to seizure activity, nutritional status, tolerance of oral feeding, prevention of UTIs, skin integrity due to immobility and incontinence, interventions to mitigate hospitalization due to severe pain or g-tube dislodgement; or amount, route, or frequency of oxygen use. During an interview on 6/13/2022 at 12:49 PM, when queried if there were skilled nursing interventions for safety measures on the plan of care, the clinical manager stated, "No." When queried if the patient used oxygen (O2), the clinical manager indicated the patient had O2 in the home, but she didn't use it		applicable laws and regulations. SPECIAL INSTRUCTION: 1. An individual Plan of Care signed by aphysician/ allowed non-physician practitioner shall be required for each clientreceiving home health and personal care services. 2. The plan of care shall be completed in full toinclude: a. ALL pertinent diagnosis (es) , principle andsecondary, including dates of onset. b. Mental status c. Type, frequency, and duration of allvisits/services. d. Specific procedures and modalities for therapyservices. e. Need for/ presence of home medical equipment andassistive devices. f. Diagnostic tests, including laboratory andx-rays. g. Surgical procedure (s). h. Prognosis. i. Rehabilitation potential. j. Functional limitations and	

	continuously. When asked how much O2, and how often it was used, the clinical manager indicated she didn't know. When queried if specific O2 information should be included on the plan of care, the clinical manager stated, "Yes." When queried to describe the patient's nutritional requirements, the clinical manager indicated she received nutrition via g-tube, and when queried if she received any other means of nutrition (oral consumption), the clinical manager stated, "No." When queried if she would expect to see patient specific nutritional requirements on the plan of care, the clinical manager stated "Yes." When queried where the patient s discharge plans were located on the on the plan of care, the clinical manager stated, "It depends ... It has to be something the [physician] would order ...." When queried if there were interventions to mitigate hospital risk, the clinical manager stated, "We would talk to the [physician] and he would write orders." When queried if there were skilled nursing interventions to address the patient's history of frequent UTIs, G tube insertion site infections, and urinary retention, the clinical manager indicated there weren't any. During an interview on 6/13/2022 at 2:05 PM, when queried if the patient was menopausal, the clinical manager stated, "She s not that old." When queried the size of the g-tube, the clinical manager indicated she wasn't sure. When queried if the size of the g-tube should be on the plan of care, the clinical manager stated, "Yes." When queried if the plan of care included emergency precautions for dislodgement of the g-tube, the clinical manager stated, "She has to go to the hospital to get it put back in ... Yes, it should be on the plan of care." 410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(C) 410 IAC 17-13-1(a)(1)(D)(i, ii, iii, vi, vii, viii, ix, x, xi, xiii)		precautions k. Activities permitted or restrictions. l. Specific dietary or nutritional requirements orrestrictions. m. Medications, treatments, and procedures. n. Medical supplies and equipment required. o. Any safety measures to protect against injury. p. Instructions to client/caregiver, as applicable. q. Treatment goals. r. Instructions for timely discharge. s. Discharge plans. t. Names and address of client’s physician/ allowednon-physician. u. Other appropriate items. v. All the above items must always be addressed onthe plan of care. 3. If a physician/ allowed non- physician	

			practitionerrefers a client under a plan of care that cannot be completed until after anassessment visit, the physician shall be consulted to approve additions ormodifications to the original plan. The skilled assessment visit order will be documentedon a doctor's /allowed non-physician order form and mailed to the physician forsignature. 4. Orders for therapy services shall include thespecific procedures and modalities to be used and the amount, frequency, andduration.	

			5. The plan of care/485 will be developed followingthe initial assessment and the original will be mailed or faxed to thephysician for signature. The plan of care is developed within five (5) workingdays or as required by agency/state guidelines. The written plan of care mustbe signed by the physician/ allowed non-physician practitioner and returned tothe agency. A copy of the plan of care shall be maintained within the client'sclinical records until the original plan of care is returned. 6. Signed physician/ allowed non-physicianpractitioner's orders will be as quickly as possible and no claims will be sentprior to receiving signed orders when required by payer 7. The client, therapist, and other agencypersonnel shall participate in developing the plan of care. The client shall beinformed of any changes in the plan of care. 8. The total plan of care shall be reviewed by theattending physician/ allowed non-physician practitioner and agency personnel asoften as the	

			severity of the client's condition this will be monitored by the Administrator	
G0578	Conformance with physician orders 484.60(b) Standard: Conformance with physician or allowed practitioner orders. Based on record review and interview, the registered nurse (RN) failed to conform with the physician's orders as noted on the plan of care for 1 of 2 records records reviewed with patients who received skilled nursing services (#4). Findings include: Clinical record review for patient #4 was completed on 6/13/2022 (start of care date 4/08/2008). The electronic medical record (EMR) evidenced the most recent plan of care	G0578	Healthmasters has updated it's Plan of Care policy (08-10-20220) for client plan of care, we held in-service with our licensed/ professional staff, (08-10-2022) to make sure every licensed/professional staff understands the important of compliance with plan of care orders. failure to comply will involve disciplinary procedure. In-services have been conducted with our nursing staff	2022-08-10

	5/24/2022, the last skilled nursing visit was made on 1/29/2021, and the last comprehensive reassessment was completed on 1/25/2022. A document titled Home Health Plan of Care & Certification for certification period 3/26/2022 to 5/24/2022 indicated skilled nursing visits were ordered every 4 weeks for administration of B12 shots and lab draws for PT/INR (a blood test for therapeutic lab monitoring of a blood thinner). The EMR failed to evidence an updated order or plan of care which discontinued the order for an agency nurse to perform blood draws and administer B12 shots every 4 weeks. A home visit was conducted on 6/10/2022 at 9:25 AM with home health aide (HHA) 1. When queried if she took blood thinners, the patient indicated she did. When queried who performed blood draws for therapeutic lab monitoring, she indicated she went to the hospital for the tests monthly. When queried if she received monthly B12 shots, and who administered them, the patient indicated she did get monthly B12 shots, and her sister administered them. During an interview on 6/13/2022 at 3:57 PM, when queried who performed monthly blood draws on the patient (#4), the clinical manager indicated she used to, but now the hospital does. When queried why, the clinical manager indicated she injured her right (dominant) arm and could no longer perform the blood draws. When queried if there was another agency nurse to perform the ordered lab draws, she indicated there was not. 410 IAC 17-14-1(a)(1)(H)		Plan of care current revision 08-10-2022: POLICY: Homecare services are furnished under the supervision anddirection of the client's physician/ allowed non-physician practitioner (NPP).The Plan of care is based on a comprehensive assessment and informationprovided by the client/ family and health team members. Planning for care is adynamic process that addresses the care, treatment and services to be provided.The plan will be consistently reviewed to ensure that client needs are met, andwill be updated as necessary, but at least every sixty (60) days. In cases where client care is provided in a clinical settingwith rotating staff of physicians/ allowed non- physician practitioner (NPP),orders shall be processed in accordance with Agency policy and the agency shallaccept the signature and date of the physician / allowed non-physicianpractitioner assigned to the clinic at the time orders are presented	

			forsignature as the attending physician / allowed non-physician practitioner forthe client. PURPOSE: To provide guidelines for agency staff to develop a plan ofcare individualized to meet specific identified needs. To reflect client's ability to make choices and activelyparticipate in establishing and following the plan designated to attainpersonal health goals. To assure that the plan meets State/Federal guidelines, andall applicable laws and regulations. SPECIAL INSTRUCTION: 1. An individual Plan of Care signed by aphysician/ allowed non-physician practitioner shall be required for each clientreceiving home health and personal care services. 2. The plan of care shall be completed in full toinclude: a. ALL pertinent diagnosis (es) , principle andsecondary, including dates of onset.	

			b. Mental status c. Type, frequency, and duration of allvisits/services. d. Specific procedures and modalities for therapyservices. e. Need for/ presence of home medical equipment andassistive devices. f. Diagnostic tests, including laboratory andx-rays. g. Surgical procedure (s). h. Prognosis. i. Rehabilitation potential. j. Functional limitations and precautions k. Activities permitted or restrictions. l. Specific dietary or nutritional requirements orrestrictions. m. Medications, treatments, and procedures. n. Medical supplies and equipment required. o. Any safety measures to protect against injury.	

			p. Instructions to client/caregiver, as applicable. q. Treatment goals. r. Instructions for timely discharge. s. Discharge plans. t. Names and address of client's physician/ allowednon-physician. u. Other appropriate items. v. All the above items must always be addressed onthe plan of care. 3. If a physician/ allowed non- physician practitionerrefers a client under a plan of care that cannot be completed until after anassessment visit, the physician shall be consulted to approve additions ormodifications to the original plan. The skilled assessment visit order will be documentedon a doctor's /allowed non-physician order form and mailed to the physician forsignature. 4. Orders for therapy services shall include thespecific	

			be used and the amount, frequency, andduration. 5. The plan of care/485 will be developed followingthe initial assessment and the original will be mailed or faxed to thephysician for signature. The plan of care is developed within five (5) workingdays or as required by agency/state guidelines. The written plan of care mustbe signed by the physician/ allowed non-physician practitioner and returned tothe agency. A copy of the plan of care shall be maintained within the client'sclinical records until the original plan of care is returned. 6. Signed physician/ allowed non-physicianpractitioner's orders will be as quickly as possible and no claims will be sentprior to receiving signed orders when required by payer 7. The client, therapist, and other agencypersonnel shall participate in developing the plan of care. The client shall beinformed of any changes in the plan of care. 8. The total plan of care shall be reviewed by theattending physician/ allowed	

			non-physician practitioner and agency personnel asoften as the severity of the client's condition policy is in effect , will be monitored by the Administrator and Board	
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on observation, record review, and	G0580	Healthmasters hired RN has Twenty years of home health careexperience,RN will be assigned to review and approve oasis timely completion,accurate	2022-08-10

	interview, the home health agency failed to ensure drugs and/or treatments were administered only as ordered on the plan of care for 1 of 3 home visits observed (#1). Findings include: An undated agency policy received 6/09/2022, titled "Physician Orders/Plan of Care" stated, "... To ensure that each patient's care is under the direction of a physician ... The physician sets up a plan of care, which includes ... medications ... treatment ... diet ... an order for each service ... All orders on the [plan of care] will be specific to the patient ... and needs ...." Observation of a home visit occurred on 6/09/2022 at 1:00 PM, with patient #1 and licensed practical nurse (LPN) 1. The patient presented up in a pressure relieving (tilting) wheelchair with head rest and wrap around leg rests, contractures to both hands, and wore ankle foot orthotics (AFOs) on both feet (braces to support feet due to foot drop/inability to hold feet up). Equipment observed included a tilt table (used to facilitate weight bearing/leg muscle strengthening [a therapy modality]), incontinence pads and adult briefs, size 14 fr (french) straight catheter kits (used to obtain urine specimens for lab testing), and g-tube (a tube inserted into the stomach for administration of nutrition, fluids, and/or medications) supplies/dressings. Observed LPN 1 provide incontinence care, and care to the patient s g-tube insertion site (mic-key button- a special low-profile tube), which was cleansed, ointment applied, and dressed with gauze. During this time, LPN 1 was queried to describe the care she provided to the patient. LPN 1 indicated she administered supplemental g-tube feedings/hydration 4 times daily, administered medications via g-tube, fed the patient a soft diet (soft in texture, minimal chewing needed, easy to swallow), provided incontinence care, showered the patient twice weekly, performed g-tube care and dressing changes, got the patient up daily for 30 minutes on the tilt table to provide leg strengthening exercise, and she cared for this patient 10 hours daily, 5 days per week. When queried if she ever needed to		completion, care plans, patient medication updates, physician contact,supervisory visits, and PRN visits. Our low census will assist our New RNto complete Oasis, start of care timely, with initial assessment requirements.Our new RN will be part of Nursing staff to assist with our Oasis, plansof care, and newly formed review process, which includes the Administrator, andRN. The process will include, over- see for timely completion, check for accuracyof oasis, plans of care, medication checks, supervisory visits, andcommunications with the Physicians. Documentation of all Oasis, plans of care, contact withpatients Physicians, and supervisory visits will be documented in newly formed reviewreport form, which will be submitted to Broad of Directors for review. updated policy will be in-serviced and issued to all nursing staff. PLANOF CARE POLICY: updated 08-10-2022 Homecare services are	

	intermittently catheterize the patient for signs/symptoms of urinary tract infection (UTI), LPN 1 indicated she did in February (2022), which resulted in the diagnosis of UTI and treatment with antibiotics. Clinical record for patient #1 was completed on 6/13/2022, start of care date 2/09/2022. A document titled Home Health Plan of Care & Certification for certification period 4/10/2022 6/08/2022, failed to include orders for the skilled nurse to administer any medications either orally or via g-tube, feed patient a soft diet, perform leg strengthening exercises with use of a tilt table for 30 minutes daily, care for/treatment of g-tube insertion site, perform intermittent catherization for signs/symptoms of UTI, apply AFOs, or provide personal care. 17-13-1(a)		anddirection of the client's physician/ allowed non-physician practitioner (NPP).The Plan of care is based on a comprehensive assessment and informationprovided by the client/ family and health team members. Planning for care is adynamic process that addresses the care, treatment, and services to beprovided. The plan will be consistently reviewed to ensure that client needsare met, and will be updated as necessary, but at least every sixty (60) days. In cases where client care is provided in a clinical settingwith rotating staff of physicians/ allowed non- physician practitioner (NPP),orders shall be processed in accordance with Agency policy and the agency shallaccept the signature and date of the physician / allowed non-physicianpractitioner assigned to the clinic at the time orders are presented forsignature as the attending physician / allowed non-physician practitioner forthe client. PURPOSE:	

			To provide guidelines for agency staff to develop a plan ofcare individualized to meet specific identified needs. To reflect client's ability to make choices and activelyparticipate in establishing and following the plan designated to attainpersonal health goals. To assure that the plan meets State/Federal guidelines, andall applicable laws and regulations. SPECIAL INSTRUCTION: 1. An individual Plan of Care signed by aphysician/ allowed non-physician practitioner shall be required for each clientreceiving home health and personal care services. 2. The plan of care shall be completed in full toinclude: a. ALL pertinent diagnosis (es) , principle andsecondary, including dates of onset. b. Mental status c. Type, frequency, and duration of allvisits/services. d. Specific procedures and modalities for therapyservices.	

			e. Need for/ presence of home medical equipment andassistive devices. f. Diagnostic tests, including laboratory andx-rays. g. Surgical procedure (s). h. Prognosis. i. Rehabilitation potential. j. Functional limitations and precautions k. Activities permitted or restrictions. l. Specific dietary or nutritional requirements orrestrictions. m. Medications, treatments, and procedures. n. Medical supplies and equipment required. o. Any safety measures to protect against injury. p. Instructions to client/caregiver, as applicable. q. Treatment goals. r. Instructions for timely discharge.	

			s. Discharge plans. t. Names and address of client's physician/ allowednon-physician. u. Other appropriate items. v. All the above items must always be addressed onthe plan of care. 3. If a physician/ allowed non- physician practitionerrefers a client under a plan of care that cannot be completed until after anassessment visit, the physician shall be consulted to approve additions ormodifications to the original plan. The skilled assessment visit order will be documentedon a doctor's /allowed non-physician order form and mailed to the physician forsignature. 4. Orders for therapy services shall include thespecific procedures and modalities to be used and the amount, frequency, andduration. 5. The plan of care/485 will be developed followingthe initial assessment and the	

			to thephysician for signature. The plan of care is developed within five (5) workingdays or as required by agency/state guidelines. The written plan of care mustbe signed by the physician/ allowed non-physician practitioner and returned tothe agency. A copy of the plan of care shall be maintained within the client'sclinical records until the original plan of care is returned. 6. Signed physician/ allowed non-physicianpractitioner's orders will be as quickly as possible and no claims will be sentprior to receiving signed orders when required by payer 7. The client, therapist, and other agencypersonnel shall participate in developing the plan of care. The client shall beinformed of any changes in the plan of care. 8. The total plan of care shall be reviewed by theattending physician/ allowed non-physician practitioner and agency personnel asoften as the severity of the client's condition	

			Licensed/ professional staff hasparticipated in in-services, and received copy of updated policy. We have two (2) RN nurses, we in-serviced, issued copy of new updatedpolicy. Medication list will be included in all home admit packet along withthe plan of care. RN nurses will be in-serviced to review the home packet(checkmedications for old med's to delete, and new med's to add) at each nursing visit, before providing service. Administrator will beresponsible for monitoring, and this will be on-going.	
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are	G0606		2022-08-29

	provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on observation, record review, and interview, the home health agency failed to ensure ongoing, interdisciplinary coordination of care for 1 of 3 home visits observed (#1). Findings include: 1. An undated agency policy received 6/13/2022, titled "Nurse Supervision" stated, "... The supervising nurse will oversee that patient communication takes place on a continuous basis ... ensure that all disciplines are aware ...." 2. An undated job description received 6/09/2022, titled "Clinical Manager/Alternate Clinical Manager" stated, "... Ensure coordination of care by all disciplines ...." 3. A job description dated 9/19/1993, titled "Home Health Care Licensed Practical Nurse [LPN] Job Description" stated, "... plans of care are discussed with ... Registered Nurse [RN] on a regular basis ...." 4. An undated job description received 6/07/2022, titled "Registered Nurse" stated, "... [Patient] assessments are communicated ...." 5. A home visit occurred on 6/08/2022 at 1:00 PM with patient #1 and licensed practical nurse (LPN) 1. When queried if the patient took foods/fluids by mouth, LPN 1 indicated she did- a soft diet (physically soft foods, making it easier to eat). Clinical record for patient #1 was completed on 6/13/2022 (start of care date 2/09/2022). A document dated and signed by LPN 1 on		Healthmasters,Inc. hasseven(7) client care staff: Two (2) RN Nurses Two (2) LPN Nurses Three (3) Home Health Aides The following updated policy outlines how we plan to correctthis deficiency on-going. The Clinical Manager will be responsible for monitoringthis policy. The Clinical Manager will meet with the client care staff monthlyto discuss this policy and any changes to the Plan of the Care. COORDINATION OFCLIENT SERVICES POLICY:	

	2/09/2022 titled "Skilled Nursing Visit Note" indicated the patient was on a soft regular diet with supplemental g-tube (a tube inserted directly into the stomach for administration of nutrition, fluids, and/or medications) feedings. A document dated and signed by the clinical manager on 2/09/2022, titled "OASIS [outcome assessment and information set] Assessment Details" (a comprehensive assessment) indicated the patient took nothing by mouth. The clinical record failed to include interdisciplinary assessment(s) occurred, to indicate LPN 1's assessment findings were relayed to the RN, for interdisciplinary visits which occurred on the same day. During an interview on 6/13/2022 at 12:49 PM, when queried to describe the patient's nutritional requirements, the administrator/clinical manager indicated the patient received nutrition/fluids through her g-tube (a tube inserted directly into the stomach). When queried if she received food/fluids by any other method/route (oral), she stated "No." 410 IAC 17-12-2(g)		The agency will integrate services, whether they areprovided directly or under contract, to assure the identification of clientneeds and factors that could affect client safety and the effectiveness of treatment.The coordination of care is provided by all disciplines and includedcommunication with physicians. PURPOSE: To coordinate care delivery to meet individual client needs. To involve the client, their representative (if any), andcaregiver in the coordination activities. To assure that the efforts of the agency personneleffectively complement one another and support the objective outlined in theplan of care. To modify the plan to reflect needs or changes identified bymembers of the team and avoid duplication of services. To determine the continuation of services and/or future plansfor care.	

			To provide the attending physician/ provider with an ongoingassessment of the client and identify the client's response to services provided. SPECIAL INSTRUCTIONS 1. Coordination of care means assuring that theclient needs are continually assessed, addressed in the plan of care, that careis delivered in a timely and effective manner, and that goals are achieved. 2. The agency will coordinate the nursing, therapy,aide, and social work services. 3. The client, representative, and caregivers willparticipate by identifying what they want to achieve and what they feelcomfortable doing. This will be built into the plan. Information provided toclients must be verbally and in writing and the agency documentation will alsoclarify what the plan is and who was informed. 4. Agency will communicate with all physicians/allowednon-physician practitioner (NPP) who are	

			writing orders regarding the plan ofcare. 5. Agency will integrate services, whether servicesare provided directly or under arrangement, to assure the identification of clientneeds and factors that could affect client safety and treatment effectivenessand the coordination of care provided by all disciplines. 6. Coordination of care will include dealing withmultiple programs for the complex clients (cardiology, wound care, diabetes,neuro, etc.) 7. Clients, their representatives, and othercaregivers will be included in the coordination activities and will receivedirect communication related to planning and changes in the plan. 8. Documentation must address the coordinationactivities and any training and education provided to the client andcaregivers. 9. When there are significant changes made to theclient's plan of care, the agency must	

			inform the client and theirrepresentative and the physician directing the care. 10. Involvement of the care team must be apparent inthe RECORDS in an electronic health record of a paper document. How and whencommunication happens must be documented. 11. The agency Clinical Manager of their designeewill develop and implement the coordination plan. 12. Coordination will include providers of care whoare not part of agency assisted living staff, outpatient wound clinics ofprivately hired caregivers. 13. The coordination activities are inclusive of thedischarge plans, physicians/ allowed non-physician practitioner (NPP) to agreeto any plan to discharge or transfer a client. 14. Each staff Registered Nurse shall meet with the clinicalManager or designee as necessary to review all areas of client needs. Thiscoordination may take place during regularly scheduled staff meetings	

			schedules and would focus on the exchange of informationbetween disciplines and the client. 15. After the initial assessment, the admitting RegisteredNurse/ Therapist shall discuss the findings of the initial visit with theClinical Manager to ensure: a. Clarification of the plan of care orders. b. Client is able to receive safe and appropriate carein his/ her place of residence. c. Client's homebound status for Medicare clients. d. Client's need for skilled nursing care. e. Need for other services and/or referral tocommunity resources. f. Availability of caregivers or support system inthe home setting. g. Coordination with other agencies andinstitutions, if need arises. 16. The agency will identify a communication systemto assure that all disciplines and	

			departments are informed of changes to plan and/ or need formodifications 17. All caregivers, including any contractedservices, shall have access to the client plan of care and will be expected toparticipate in care conferences and other coordination activities, as appropriate. 18. Reports can be used to identify changes infrequency of services, notice of hospitalization or to communicate statuschanges. COORDINATIONOF CLIENT SERVICES POLICY:	

			The agency will integrate services, whether they areprovided directly or under contract, to assure the identification of clientneeds and factors that could affect client safety and the effectiveness of treatment.The coordination of care is provided by all disciplines and includedcommunication with physicians. PURPOSE: To coordinate care delivery to meet individual client needs. To involve the client, their representative (if any), andcaregiver in the coordination activities. To assure that the efforts of the agency personneleffectively complement one another and support the objective outlined in theplan of care. To modify the plan to reflect needs or changes identified bymembers of the team and avoid duplication of services. To determine the continuation of services and/or future plansfor care.	

			To provide the attending physician/ provider with an ongoingassessment of the client and identify the client's response to services provided. SPECIAL INSTRUCTIONS 1. Coordination of care means assuring that theclient needs are continually assessed, addressed in the plan of care, that careis delivered in a timely and effective manner, and that goals are achieved. 2. The agency will coordinate the nursing, therapy,aide, and social work services. 3. The client, representative, and caregivers willparticipate by identifying what they want to achieve and what they feelcomfortable doing. This will be built into the plan. Information provided toclients must be verbally and in writing and the agency documentation will alsoclarify what the plan is and who was informed. 4. Agency will communicate with all physicians/allowednon-physician practitioner (NPP) who are	

			writing orders regarding the plan ofcare. 5. Agency will integrate services, whether servicesare provided directly or under arrangement, to assure the identification of clientneeds and factors that could affect client safety and treatment effectivenessand the coordination of care provided by all disciplines. 6. Coordination of care will include dealing withmultiple programs for the complex clients (cardiology, wound care, diabetes,neuro, etc.) 7. Clients, their representatives, and othercaregivers will be included in the coordination activities and will receivedirect communication related to planning and changes in the plan. 8. Documentation must address the coordinationactivities and any training and education provided to the client andcaregivers. 9. When there are significant changes made to theclient's plan of care, the agency must	

			inform the client and theirrepresentative and the physician directing the care. 10. Involvement of the care team must be apparent inthe RECORDS either in an electronic health record of a paper document. How andwhen communication happens must be documented. 11. The agency Clinical Manager of their designeewill develop and implement the coordination plan. 12. Coordination will include providers of care whoare not part of agency assisted living staff, outpatient wound clinics ofprivately hired caregivers.l 13. The coordination activities are inclusive of the discharge plans,physicians/ allowed non-physician practitioner (NPP) have to agree to any planto discharge or transfer a client. 14. Each staff Registered Nurse shall meet with the clinicalManager or designee as necessary to reviewall areas of client needs. This coordination may take place during	

			meetings the review clients, care plan, visit schedules andwould focus on the exchange of information between disciplines and the client. 15. After the initial assessment, the admitting RegisteredNurse/ Therapist shall discuss the findings of the initial visit with the Clinical Manager to ensure: a. Clarification of the plan of care orders. b. Client is able to receive safe and appropriate carein his/ her place of residence. c. Client's homebound status for Medicare clients. d. Client's need for skilled nursing care. e. Need for other services and/or referral tocommunity resources. f. Availability of caregivers or support system inthe home setting. g. Coordination with other agencies andinstitutions, if need arises. 16. The agency will identify a	

			communication systemto assure that all disciplines and departments are informed of changes to planand/ or need for modifications 17. All caregivers, including any contractedservices, shall have access to the client plan of care and will be expected toparticipate in care conferences and other coordination activities , as appropriate. 18. Reports can be used to identify changes infrequency of services, notice of hospitalization or to communicate statuschanges.	
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager.	G0622	all agency patient are supplied with the cell phone for the administrator and alternative administrator, both are available 24 hours , seven days a week for healthmasters patients. However, per surveyor, we will supply written contact information ,to be placed in the patients home. we are updating change to all start of care patient information. this information will be placed in all patients	2022-08-19

	Based on record review and interview, the home health agency failed to ensure it provided the name and contact information for the clinical manager to all agency patients. Findings include: On 6/09/2022 at 12:00 PM, the alternate administrator submitted the agency's admission packet/home folder for review. The admission packet/home folder failed to include the name and contact number for the clinical manager. During an interview on 6/13/2022 at 4:02 PM, the alternate administrator and administrator/clinical manager were queried where name and contact information for the clinical manager was documented in the admission packet/home folder. During this time, the clinical manager indicated all the patients had her personal cell phone number if they needed to reach her. No further information was provided.		homes. We are contracting with medical exchange answering service inc ,a medical phone answering service. this service will be operational when office is closed. alternate Administrator, will over see monitoring of this policy; this is an ongoing policy	
G0640	Quality assessment/performance improvement 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of	G0640	Healthmasters,Inc has conducted QAPI meetings with staff,but failed to document the meeting with written minutes. Several meetingscovered the following: 1. Covid 19 topic and precautions, 2. Vaccination for Covid19, 3. Staff requirements for employment 4. Distribution of Covid 19 protectionequipment. Staff were issued the following protective equipment: 1.	2022-08-29

	emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Based on record review and interview, the home health agency (HHA) failed to develop, implement, evaluate, or maintain a quality assurance/performance improvement (QAPI) program or maintained documentary evidence of its QAPI program. This practice had the potential to affect all agency patients. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR §484.65: Quality Assessment and Performance Improvement (QAPI). Findings include: An undated agency policy received on 6/09/2022 titled "Quality Assessment & Performance Improvement Plan" indicated the agency would establish and maintain an ongoing Quality Assessment & Performance Improvement (QAPI) program. During an interview on 6/10/2022 at 11:00 AM, the surveyor requested to review the agency's QAPI program and correlating documents, to which the alternate administrator indicated there was "nothing", it was very far behind, and (they) had nothing to submit. When queried if there were any performance improvement projects (PIPs) or areas of focus, the administrator and alternate administrator indicated there were not. Upon exit, no further information was provided for review. 410 IAC 17-12-2(a)		Gowns (fully covered torso from neck to knees,arm to end of wrists and wraps around the back, fasten in back of neck andwaist). 2. Mask and respirators 3. Goggles and face shield 4. Gloves. In meetinginstructive demo was given on use of equipment. All of our employees are fully vaccinated for Covid 19 and copiesof vaccination cards are in our employee health files. All of our patients arefully vaccinated. our committee(all client care staff) ,will began having QAPI, meetings on a monthly basis utilizing the policy below as our guide. Minutes will be forwarded to the Board for review and monitoring asistance . This will correct this deficiency. The updated policy, meeting minutes, and Board review will prevent this deficiency from recurring. updated policy is as follows: **QUALITYASSESSMENT AND Performance** **Improvement(QAPI)**	

			POLICY Agency will develop, implement, evaluate, and maintain an effective,ongoing agency wide, data driven QAPI program. This plan will be based on the organization'smission and goals and designed to improve client outcomes and the perceptionsof clients/families about the quality and value of services. The agency will maintain documentary evidence of its QAPIprogram and be able to demonstrate its operation to CMS. **PURPOSE** To monitor theeffectiveness and safety of services and the quality of care. To identify opportunitiesfor improvement. To useperformance improvement activities to track adverse client events, analyzetheir causes and implement preventive actions. To measureagency success and ensure that improvements are sustained.	

SPECIAL INSTRUCTIONS

1. The agency's governing body mustensure that the program reflects the complexity of its organization andservices, involves all services including those provided under contract, andfocuses on indicators related to improved outcomes. This includes the use ofemergent care services, hospital admissions and readmissions.

2. The program will address the agencyperformance across the spectrum of care including the prevention and reductionof medical errors.

3. The agency will maintain documentationof its QAPI program and be able to demonstrate its operation to CMS.

SCOPEOF PROGRAM

1. Theprogram will be capable of showing measurable improvement in indicators thatwill improve health outcomes, client safety, and quality of care.

2. Theagency will identify, measure, analyze, and track

			quality indicators thatinclude client adverse events, and other relevant data to assess processes ofcare, services, and operations. 3. Thefrequency and detail of the data collection must be approved by the governingbody. **STANDARDPROGRAM ACTIVITIES** 1. Theagency's performance improvement activities will focus on high risk, highvolume, or problem prone areas that are specific to this agency. 2. Theprogram and committee will consider incidence, prevalence and severity of theproblems with these areas. 3. Theprograms activities will lead to an immediate correction of identified problemsthat directly or potentially threaten health and safety of clients. 4. Adverseevents will be tracked and analyzed for cause and document the implementationof preventative actions. 5. Theagency will take actions	

			that address the agency's performance across thespectrum of care, including the prevention and reduction of medical errors. 6. Theprogram will establish timelines for review to measure success and establishongoing activities to sustain the success. 7. Theagency must maintain documentary evidence of its QAPI Program and be able todemonstrate its operation to CMS. **PERFORMANCEIMPROVEMENT PROJECTS** 1. **Beginning July 13, 2018, agencies mustconduct performance improvement projects** a. Thenumber and scope of distinct improvement projects conducted annually mustreflect the scope, complexity, and past performance of the agency services andoperations. b. Theagency must document the quality improvement projects undertaken, the reasonsfor conducting these projects and the measurable	

			theseprojects. **c. Thegoverning body is responsible for ensuring the following:** i Anongoing program for quality improvement and patient safety is defined,implemented, and maintained. ii Theagency wide assessment and performance improvement efforts address prioritiesfor improved quality of care and client safety. iii All improvement actions will beevaluated for effectiveness. iv Clear expectations for client safetyare established, implemented, and maintained. Any findings of fraud or waste are appropriat Administrator will be responsible. The meetings will be ongoing	
G0680	Infection prevention and control	G0680	Healthmasters,Inc has conducted QAPI meetings with	2022-09-01

	484.70 Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. Based on observation, record review and interview, the home health agency failed to maintain a coordinated agency-wide infection control program as part of the agency's quality assessment and performance improvement (QAPI) program (see tag G680); failed to provide staff with infection control education at least annually, provide staff, patients and/or caregiver(s) with COVID-19 pandemic education, and failed to provide staff with COVID-19 vaccination mandate requirements (see tag G686); and failed to ensure all staff was fully vaccinated for COVID-19, develop and implement policies and procedures to ensure that all staff were fully vaccinated for COVID-19, a process for tracking and securely documenting the COVID-19 vaccination status of all staff, or contingency plans for staff with no proof they were fully vaccinated for COVID-19 (see tag G687). This practice had the potential to affect all agency patients. Findings include: The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR §484.70: Infection Prevention and Control.		staff,but failed to document the meeting with written minutes. Several meetingscovered the following: 1. Covid 19 topic and precautions, 2. Vaccination for Covid19, 3. Staff requirements for employment 4. Distribution of Covid 19 protectionequipment. Staff were issued the following protective equipment: 1. Gowns (fully covered torso from neck to knees,arm to end of wrists and wraps around the back, fasten in back of neck andwaist). 2. Mask and respirators 3. Goggles and face shield 4. Gloves. In meetinginstructive demo was given on use of equipment. All of our employees are fully vaccinated ,for Covid 19 and copiesof vaccination cards are in our employee health files. All of our patients arefully vaccinated With our addition to the RN staffing, our committee willbegan documenting all QAPI related meeting , and forwarded to the Broad of Directorsfor review. This will take place monthlly	

			updated policy and Guideline has our Covid 19 vaccination mandate policy. Administrator will be responsible. The meetings will be ongoing	
G0684	Infection control 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Based on observation, record review and interview, the home health agency failed to maintain a coordinated agency-wide infection control program as part of the agency's quality assessment and performance improvement (QAPI) program, and failed to document patient infections for 2 of 2 home visits	G0684	Healthmasters had two (2) patients who contracted infections, which were not reported either on report notes, or verbally to clinical Manager. Both cases should have been reported to the Clinical Manager. Both case should have been addressed in a QAPI meeting setting . We will correct this deficiency by using our QAPI committee (care contact staff), and Governing body. QAPI meetings will be held monthly and ,or as needed. The following two policies will outline how we will address these two case in our QAPI meeting. Utilizing our QAPI system will prevent this deficiency from recurring. ,	2022-09-01

5).

Findings include:

1. An undated agency policy received on 6/09/2022 titled "Quality Assessment & Performance Improvement Plan" indicated the agency would establish and maintain an ongoing QAPI program, which included infection control activities.

2.. An undated agency policy received on 6/07/2022 titled "Infection/Exposure Control Plan" stated, "... Purpose ... To define the mechanism that the organization will use to address surveillance, identification of infections among staff and patients ... Agency will ... measure, assess ... prevention and control of infections monthly ... Provide ... systems to track ... infections ... Require documentation of infections that are acquired while the patient is receiving services from the Agency ...."

3. A home visit was conducted on 6/08/2022 at 1:00 PM, with patient #1 and licensed practical nurse (LPN) 1. When queried if the patient experienced any recent infections, LPN 1 indicated the patient had a UTI (urinary tract infection) and was treated with antibiotics in February 2022. Observed the empty prescription bottle for cipro (an antibiotic), which was filled on 2/01/2022.

Clinical record for patient #1 was completed on 6/13/2022, start of care date 2/09/2022. A document dated 2/09/2022 titled "Skilled Nursing Visit Note" indicated the patient began taking antibiotics for UTI.

INFECTION CONTROL PLAN

PURPOSE

Theinfection control plan defines the structure and activities for surveillance,prevention and control of infections among clients, employees and all otherswho come into contact with clients and establishes responsibility for over siteof these activities. The Agency has developed an Infection Control Plan thatconforms to OSHA regulations, CDC guidelines, Joint Commission, CHAP, and ACHCrequirements, state and local regulations and commonly accepted Standards ofPractice.

AUTHORITY

Thehome care management team including the Director of Clinical Services, QualityImprovement Coordinator and others as designated have the authority for routineidentification and analysis of the incidence and

	4. A home visit was conducted on 6/08/2022 at 2:30 PM, with patient #5 and home health aide (HHA) 2. When queried if the patient experienced any recent hospitalizations or emergency department (ED) visits, the patient indicated she was seen in the ED on 4/16/2022 for COVID-19, and tested (+).positive. Clinical record review for patient #5 was completed on 6/13/2022 (start of care date 3/18/2017). Documents dated 4/16/2022 and 4/17/2022 titled "Aide Visit Note - Daily" failed to indicate the patient was seen in the ED or tested (+) for COVID-19. 5. On 6/07/2022 at 12:09 PM, surveyor requested (to the alternate administrator) to review the agency's Infection log. Upon survey exit, nothing was submitted. 6. During an interview on 6/10/2022 at 11:00 AM, the surveyor requested to review the agency's QAPI program and correlating documents, to which the alternate administrator indicated there was "nothing", it was very far behind, and (they) had nothing to submit. When queried if there were any performance improvement projects (PIPs) or areas of focus, the administrator and alternate administrator indicated there were not. Upon exit, no further information was provided for review.		cause of all infections andshall develop and implement a plan for surveillance, prevention and control ofinfection hazards. **SURVEILLANCE** Theactivities related to the Infection Control Surveillance Plan shall be based onan assessment of the population served by the agency, Joint Commission, CHAP,and ACHC indicators, high risk and high volume indicators, CDC definition ofinfections, and assessed agency needs based on data collection. **ORIENTATIONAND CONTINUING EDUCATION OF PERSONNEL** Allnew employees of the agency shall complete an education session that coversBlood Borne Pathogen Exposure Control Plan, Tuberculosis Plan, COVID-19 PLAN,CDC’s Hand Hygiene Guidelines and basic infection control. Ongoing educationwill also be provided to employees, clients, and visitors, utilizing a varietyof formats and modalities, and based on the most current CDC, and OSHAguidelines, state	

accrediting bodies.

REPORTSTO PUBLIC HEALTH OFFICIALS

Dataobtained through surveillance activities shall be appropriately organized andreported to Public Health officials in a timely manner for their review andaction.

EMPLOYEEHEALTH

Theagency shall develop policies and procedures related to surveillance,prevention and control of employee infection, including pre-employmentassessments, immunizations, exposures to Blood Borne Pathogens and otherinfectious agents, and annual health screening. The agency will promoteemployee vaccination for vaccine preventable diseases, i.e. Influenza. Theagency will work with employees to create new programs, resolve problems, andpromote knowledge of their responsibilities in personal health and InfectionControl.

AGENCYINFECTION CONTROL PLAN

			Policies andprocedures shall describe activities of prevention and control of infections inall client care activities. Infection control policies and procedures shall bereviewed annually or as indicated. The Infection Control Committee and/or the QAPICommittee, and input from the Governing body will approve the policies andprocedures. **PERFORMANCEIMPROVEMENT PLAN** InfectionControl surveillance indicators will be included in the activities reviewed andthe data collected as part of the agency performance improvement plan. Datacollected and reports or other information relating to the condition andtreatment of any person that is used for improving agency performance andenhancing client care is declared to be privileged information. **TUBERCULOSISCONTROL PLAN** This plan iswritten to ensure	

			compliance with the Guidelines for preventing transmission ofMycobacterium Tuberculosis in health care settings. The plan is based on a TBrisk assessment of the agency's client population, identifying the number ofsuspected or confirmed infectious TB cases treated in the previous year. Theplan establishes guidelines for isolation as needed, respiratory protectioneducation and training for all staff, TB exposure follow-up, and pre-employmentand annual employee testing. **EXPOSURECONTROL PLAN** The ExposureControl Plan shall be written to ensure compliance with the requirements forOccupational Exposure to Blood Borne Pathogens and shall include guidelines foremployee risk assessment by job classification and task, employee education andtraining, engineering controls, Personal protective equipment (PPE), exposurefollow up and related treatment and record keeping,	

			Infection Control Committee or other designated group. **DISASTER/EMERGENCY PLAN** The agencywill develop a plan to coordinate a response to disasters and potential clientsurge conditions, including bio-terrorist attacks. The agency will work withcommunity organizations to clarify roles in disaster situations. **PREVENTION** Education forstaff, clients and visitors will continue with signs and other methodsregarding hand hygiene and cough hygiene importance for staff and clients. **INFECTIONCONTROL SURVEILLANCE** **POLICY** Agency willestablish a continuous data monitoring and collecting system to detectinfections or identify	

			three types ofsurveillance that may be used are: · Totalsurveillance – all infections identified in clients and employees. · Targetedsurveillance – specific infections, populations, or procedures. · Outbreaksurveillance – specific infections or infection clusters within multipleindividuals at the same time. The Agency willimplement a process of identifying all infections in the client and/or employeepopulation and evaluate effectiveness of current control measures or identifyan action plan to improve incidence of infections. **SPECIAL INSTRUCTIONS**	

			· TheAgency will perform targeted infection control surveillance as follows: Client infections that will be reported at the time of admission includeHepatitis B and C, MRSA, VRE, TB or any reportable communicable disease (asdefined by the health department). · Client infections to bereported while the client is receiving services from the agency: woundinfections that develop thirty (30) days or greater after admission thatrequire antibiotic treatment or are identified by lab test. · IV site infections that developten (10) days after admission or at any time if the IV cannula was inserted byAgency staff; and all infections identified are to be reported upon admission. · Employee infections areto be reported if an employee develops or has a known exposure to conjunctivitis,MRSA, VRE, COVID-19 and any reportable communicable disease as defined by localhealth department.	

			1. Theagency staff will attempt to identify the source of infection to determine ifit was acquired while the client was receiving home care *(agency-acquired),* from the community *(community-acquired)*, or during a recent inpatient facility stay *(nosocomial)*. 2. Themost common nosocomial infections in adults are urinary tract infections,surgical site infections, lower respiratory infections such as pneumonia, andbloodstream infections. 3. Acommunity-acquired infection would be monitored through outbreak surveillance.This would include infections such as salmonella or Hepatitis A. 4. Ahome-acquired infection *(agency acquired)*results from contact between a client and a staff member during the timethe agency is providing home care services. This may include transmission fromeither the staff member to the client or the client to the staff member. a. Currently, there is no	

			nationallyaccepted criteria that defines an organization-acquired infection or acceptableinfection rates. Therefore, they will be defined by the agency. b. When a pattern or trend in infectionsis identified, the agency will investigate where clients and/or staff may haveacquired the infections and what the source of contamination was. c. Data regarding infections may beobtained from a number of sources including home visits, verbal orders forantibiotics or culture and sensitivity orders, laboratory reports, andinterviews with staff. d. If infections are identified as,"agency-acquired," an investigation will be done to determine if the cause isone of the following: · Employeesnot following agency policies and procedures. · Employeestransmitting infections among clients they see on home visits. · Employeesand/or clients	

			or supplies. 5. The agency will closely monitor andinvestigate employee's occupational exposure to determine the cause. Anyillness or injury resulting from the health care professional's client careactivities will be closely monitored. 6. An infection control log will bemaintained. The agency will identify follow-up actions taken as a result ofidentified infections. Information will be integrated into orientationin-services and quality improvement activities. 7. Targeted surveillance activities willbe identified and implemented based on the results of the total surveillanceprogram. 8. Data related to identified infectionswill be reviewed and analyzed. Policies and procedures will be reviewed inlight of infection surveillance reports and updated as needed to address areasof concern. All changes and/or modifications to agency policies and procedureswill be communicated to employees	

			and clients appropriately. All infectioncontrol policies will be reviewed at least annually.	
G0686	Infection control education 484.70(c) Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). Based on observation, record review, and interview, the home health agency failed to provide staff with infection control education at least annually; failed to provide employees, patients and/or caregiver(s) with COVID-19 pandemic education; and failed to provide employees with COVID-19 vaccination mandate requirements, for 5 of 5 employee records reviewed (Registered nurse [RN] 2, licensed practical nurse [LPN] 1, home health aide [HHA] 1, HHA 2, and HHA 3), and 3 of 3 home visits observed (#1, 4, 5). Findings include: 1. An undated agency policy received on 6/07/2022 titled "Infection/Exposure Control Plan" stated, "... Agency will ... Educate Agency personnel, patient, families/caregivers ... in the prevention and control of infections ... Infection control in services shall be scheduled no less than annually ... Attendance shall be ... documented ... Records of in service attendance shall be maintained in the personnel file ...." 2. Employee record review for HHA 1 (date of	G0686	Healthmasters has updated its infection control/exposurecontrol plan which covers staff education and training, this will correct this deficiency. All materials related to OSHA regulations and allHealthmasters infection control activitiesshall be incorporated into an infection control plan which includes: An outline for employee education Record of employee training Standard precaution procedures Isolation procedures , when and if appropriate in-home caresetting Clinical procedures for obtaining , handling, andtransporting laboratory	2022-09-01

	which failed to include documentation for any in-services. 3. Employee record review for HHA 2 (date of hire 3/13/2017) was completed on 6/9/2022, which failed to include any documented in-services. 4. Employee record review for HHA 3 (date of hire 7/31/2009) was completed on 6/9/2022, which failed to include any documented in-services. 5. Employee record review for LPN 1 (date of hire 8/16/2006) was completed on 6/09/2022, which failed to include any documented in-services. 6. Employee record review for RN 2 (date of hire 3/11/2015) was completed on 6/09/2022, which failed to include any documented in-services. 7. During an interview on 6/09/2022 at 2:44 PM, when queried where annual in-service training was documented, the alternate administrator indicated it was documented in the agency's in-service binder. No further information was provided. 8. During an interview on 6/09/2022 at 3:40 PM, when queried if there was a separate in-service binder kept, person 3 (human resource manager) stated, "Yes." No further information was provided. 9. During an interview on 6/13/2022 at 4:08 PM, the agency's in-service binder was requested for review, to which the alternate administrator stated, "We had one, but I don t know where it is." When queried when the last in-service occurred, the alternate administrator stated, "I don't know ... a long time ...."		specimens Decontamination and labeling procedures Documentation of investigation of exposure incidents andinfection occurrences Contracts for infection control-related services, such aswaste disposal ** Client and employee confidentiality will be consideredand, as appropriate, information may be maintained in the clinical record orthe employee’s personnel file or separate confidential files. Employes will be informed of risk factors andperformance/compliance requirements during, but not limited to, the followingtimes: New employee orientation In-service/continuing education programs Employee supervision Employee performance evaluation	

	10. An interview was conducted with person 4 (emergency preparedness [EP] manager) on 6/13/2022 at 11:37 AM. When queried when the last time the Emergency Plan was reviewed, he indicated it was about 3 years ago, and nothing has been done since COVID-19 began. During this time, he submitted a document titled Individual Emergency Plan which was given to each patient. This document failed to include mitigation/education for COVID-19. When queried the last time he administered EP training with employees, he indicated it was about 3 years ago, but it wasn't documented. 11. On 6/09/2022 at 12:00 PM, the alternate administrator submitted the agency's admission packet/home folder for review, which failed to include educational information for COVID-19. 12. During an interview on 6/10/2022 at 11:10 AM, the agency's admission packet/home folder was reviewed. When queried if the agency provided patient information/education on COVID-19, person 3 (human resource manager) indicated they did not. 13. A home visit was conducted with patient #1 on 6/08/2022 at 1:00 PM. Surveyor did not observe a home folder. When queried, LPN 1 indicated there was no home folder located in the patient's home. 14. A home visit was conducted with patient #4 on 6/10/2022 at 9:25 AM. Observed the patient's home folder, which failed to include any COVID-19 information/educational documents. 15. A home visit was conducted with patient #5 on 6/08/2022 at 2:30 PM. Observed the patient's home folder, which failed to include		Employee counseling/discipline Healthmasters will review and analyze infection data in aneffort to identify trends or patterns. Covid 19 protection and procedures will be incorporated intoour existing infection control plan. Vacciines will be the most important thing staff can do,this mean also encouraging client to get vaccine when available. Staff notfully vaccinated will not be permitted to provide care, treatment , or other servicesfor Healthmasters, or its clients. The following policies will be utilized for correcting and preventing recurring deficiency: **INFECTION CONTROLEDUCATION/TRAINING** **POLICY** For each twelve(12) months of employment, all employees and contractors who have contact withthe clients in the clients' residence shall complete in-service training	

	documents.		aboutinfection control practices to be used in the home. **SPECIAL INSTRUCTIONS** 1. Infectioncontrol training during agency orientation will include the followinginformation. This will be provided using written materials, videos, orientationto clinical settings and other methods appropriate for specific situations. a. Employeehealth requirements. b. Personalhygiene. c. Infectioncontrol policies. d. Healthand transmitted infections. e. Isolationprecautions (applicable to home care). f. Aseptictechnique (if applicable to position and responsibilities). g. Standardprecautions: · Handwashingtechniques and personal protective equipment. h. Hazardouswaste disposal: · Disposalof contaminated	

			materials and equipment, including dressings, needles,syringes, and razor blades. i. Cleaningand sterilization of equipment and devices: · Disinfectingreusable equipment. · Disinfectingenvironmental surfaces. j. Exposureto blood borne pathogens and tuberculosis, and other infections in theenvironment such as COVID-19. k. Agency-specificinfection control procedures. l. Othertopics as required. 2. Employee education shall occur at thetime of employment, within thirty (30) days of when changes occur, andannually. Records of such training shall be maintained in accordance with thepolicy for retention of records, but not less than three (3) years. 3. Annual infection control training willfocus on changes in policy or regulation and topics	

			agency. 4. Material appropriate in content andvocabulary to employees' educational level, literacy, and language shall beused. The person conducting the training shall be knowledgeable in the subjectmatter covered by the training outline. An opportunity for questions and answersshall be provided. 5. Training records will include dates,contents of the training sessions, names and qualifications of instructors, andthe names and job titles of attendees. Administrator will monitor this policy; policy will be on-going	
G0687	COVID-19 Vaccination of Home Health Agency staff 484.70 (d)-(d)(3)(i-x) § 484.70 Condition of Participation: Infection Prevention and Control.	G0687	Healthmasters has updated its COVID 19 Vaccination policy: **COVID-19 VACCINE POLICY**	2022-08-29

	(d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and (ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section.		**POLICY** As a condition of participation, CMS requireshome health agencies to develop and implement policies and procedures to ensurethat all staff are fully vaccinated for COVI-19. Staff is defined as “individuals who provideany care, treatment, or other services for the agency or its clients. **Fully vaccinated means**: • Two weeks or more after completing a primary vaccination series for COVID-19. • Two weeks or more since the administration of a single dose vaccine or the administration of all required doses of multi-dose vaccine. • If the employee is granted an exemption based on recognized medical conditions or sincere religious beliefs consistent with federal law, the mandate will not apply to them. Regardless of clinical responsibility orclient contact,	

	(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients; (ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (d)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an		the policies and procedures must apply to the following agencystaff, who provide any care, treatment, or other services for the agency and/orits clients: · Agencyemployees · Licensepractitioners · Students,trainees, and volunteers; and · Individualswho provide care, treatment, or other services for the agency and/or itsclients, under contract or by arrangement. This includes hospice and dialysis staff, physical, occupational orspeech therapists, mental health professionals, licensed practitioners or adultstudents, trainees of volunteers. **The COVID-19 vaccine requirements do not applyto**:	

	vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the HHA has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the HHA's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and		· Staffwho exclusively provide telehealth or telemedicine services outside of thesettings where home health services are directly provided to clients and who donot have any direct contact with clients, families, and caregivers, and otherstaff. Staff who provide support services for theagency that are performed exclusively outside of the settings where home healthservices are provided directly to clients and who do not have any directcontact with clients, families, and caregivers. **SPECIAL INSTRUCTIONS** **1.** All staff who are fully vaccinated will havedocumentation of the vaccinations that include the vaccine received, date(s) ofvaccinations and boosters if received, in their personnel files. Staff who have not completed thevaccination series must have documentation of the doses received and dates forfuture vaccinations. **2.** Agency will identify person/departmentresponsible	

	(x) Contingency plans for staff who are not fully vaccinated for COVID-19. Based on record review and interview, the home health agency failed to ensure all staff was fully vaccinated for COVID-19; failed to develop and implement policies and procedures to ensure that all staff were fully vaccinated for COVID-19 for 5 of 9 reported employees; or a process for tracking and securely documenting the COVID-19 vaccination status of all staff, or contingency plans for staff with no proof they were fully vaccinated for COVID-19. Findings include: An agency policy received on 6/09/2022, titled "2022 Coronavirus Policy", failed to indicate how the agency ensured all staff were fully vaccinated for COVID-19, a process for tracking and securely documenting the COVID-19 vaccination status of all staff, or contingency plans for staff with no proof they were fully vaccinated for COVID-19. During an interview on 06/09/2022 at 2:13 PM, when queried if the agency had any other policies/procedures for COVID-19 aside from the policy titled "2022 Coronavirus Policy", the alternate administrator stated, "... Um [sic] no ... COVID is new ... It keeps evolving." During an interview on 06/09/2022 at 2:19 PM, person 3 (human resource manager) submitted an undated, untitled document, which, per person 3, was the list of the agency's employees. registered nurse (RN) 2, licensed practical nurse (LPN) 1, home health aide (HHA) 1, HHA 2, and HHA 3 were included on the list, and the list indicated all 5 employees were vaccinated. The administrator/clinical manager was not included on the list. When queried for proof of vaccination, person 3 indicated RN 2 and LPN 1 misplaced their vaccination cards, and he was still waiting for them to submit their cards. At 2:31 PM, when queried about the administrator/clinical manager's proof of vaccination, person 3 indicated he thought her		for obtaining and updating employee files to reflect compliancewith vaccinations or exemptions. **3.** Agency will provide medical or religiousexemption forms for staff seeking exemptions. This documentation must be filled out completely and signed by theappropriate health care or religious person. Documentation must be in the employee personnel file. **4.** If the request for an exemption is denied, theemployee will not be able to work unless receive the vaccine, and employmentmay be terminated. **a.** Medical Exemptions: **i.** Documentationthat confirms recognized clinical contraindications to COVID-19 vaccines andwhich supports staff requests for medical exemptions from vaccination will besigned by a licensed practitioner, who is not the person requesting exemptions. The practitioner is acting within theirrespective scope of practice and in accordance with all	

	vaccine card "was at home". Surveyor observed submitted copies of vaccination cards for LPN 2 (not on the list), person 3, HHA 1, and HHA 3. Upon survey exit, no proof of vaccination was submitted for the administrator/clinical manager, the alternate administrator, HHA 2, RN 2, or LPN 1. Of 9 total known employees, the agency demonstrated 44% compliance with the COVID-19 vaccine mandate.		applicable State andlocal laws, and for ensuring that the documentation contains: **1.** All information specifying which of theauthorized COVID-19 vaccines are clinically contraindicated for the staffmember to receive and the recognized clinical reasons for thecontraindications; and **2.** A statement by the authenticating practitionerrecommending that the staff member be exempted from the agency's COVID-19vaccination requirements for staff based on the recognized clinicalcontraindications **5.** Agency will develop a process for ensuring thetracking and secure documentation of the vaccination status of staff for whomCOVID-19 vaccination must be temporarily delayed, as recommended by the CDC,due to clinical precautions and considerations, including but not limited to ,individuals with acute illness secondary to COVID-19, and individuals whoreceived monoclonal antibodies or convalescent plasma for COVID-19	

			treatment;and contingency plans for those staff who are not fully vaccinated forCOVID-19. **DOCUMENTATION OF STAFF VACCINATIONS** 1. Agency must track and securely document the vaccination status of each staff member, including those for whom there is a temporary delay in vaccination. 2. Vaccine exemption requests and outcomes must also be documented. This will be an ongoing process as new staff are hired. 3. All medical records, including vaccine documentation must be kept confidential and stored separately from an employer's personnel files, pursuant to ADA and the Rehabilitation Act. 4. Examples of acceptable forms of proof of vaccination include: a. CDC COVID-19	

vaccination record card (or a legible photo of the card)

b. Documentation of vaccination from a health care provider or electronic health record

c. State immunization information system record

d. If vaccinated outside of the U.S., a reasonable equivalent of any of the previous examples would be acceptable.

5. Providers have the flexibility to use the tracking tools of their choice. (*For those who would like to use it, CDC provides a staff vaccination tracking tool that is available on the NHSN(National Healthcare Safety Network) website. This is Excel based tool available at no charge.)*

VACCINEEXEMPTIONS

1. Agency will establish and implement a process by

an exemption from COVID-19 vaccination requirements based on an applicable Federal law. Certain allergies recognized medical conditions, or religious beliefs, observances, or practices may provide grounds for exemption.

2. Providers must comply with applicable Federal anti-discrimination laws and civil rights protections. Applicable laws include:
    a. Americans with Disabilities Act (ADA)
    b. Section 504 of the Rehabilitation Act (RA)
    c. Title VII of the Civil Rights Act of 1964
    d. Pregnancy Discrimination Act; and
    e. Genetic Information Nondiscrimination Act.
3. For more information about these situations, employers may consult the Equal Employment Opportunity Commission's website.
4. Requests for exemptions based on an applicable

			Federal Law must be documented and evaluated in accordance with applicable Federal law and each provider's policies and procedures. 5. For staff members who request a medicalexemption from vaccination, all documentation confirming recognized clinicalcontraindications to COVID-19 vaccines, and which support the staff member's requestmust be signed and dated by a licensed practitioner, who is not the personrequesting the exemption. This person isacting within their respective scope of practice as defined by, and inaccordance with all applicable state and local laws. The documentation must contain allinformation specifying which of the authorized vaccines are contraindicated forthe staff member to receive and the recognized clinical reasons for thecontraindications; and a statement by the practitioner recommending the staffmember be exempt from the vaccination requirements. **INFECTIONPREVENTION AND**	

			CONTROL Agenciesmust have a process for ensuring the implementation of additional precautions,intended to mitigate the transmission, and spread of COVID-19, for all staff who are not fully vaccinated forCOVID-19. Medicarecertified home care providers have been following nationally recognized infection prevention and controlguidelines. These processes must includethe implementation of additional precautions for staff who are not fullyvaccinated. CONTINGENCYPLANS 1. Staff who are not fully vaccinated will notprovide care, treatment, or other services for the agency or its clients untilthey have completed the primary vaccination series for COVID-19 and areconsidered fully vaccinated, or at a minimum, have received a single dose vaccine or the first dose of the vaccinationseries. 2. Planning must also address	

			the safe provision of services by individualswho have requested an exemption from vaccination while their request is beingconsidered. Administrator will monitor this policy: policy is on-going	
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on observation, record review, and interview, the home health agency failed to ensure the registered nurse (RN) and/or licensed practical nurse (LPN) completed clinical documents to include assessment findings, and/or medications/treatments administered, for 1 of 1 home visits with skilled nursing services (#1). Findings include: An undated agency job description titled "... [LPN] Job Description" stated, "... clinical records are documented ... Procedures and treatments are implemented accurately and documented appropriately ...."	G0716	Healthmasters has updated a policy for ClinicalDocumentation: This policy will assist in correcting this deficiency, and prevent it from recurring. **CLINICALDOCUMENTATION** **POLICY** Agency willdocument each direct contact with the client. This documentation will becompleted by the direct caregivers and monitored by the skilled professionalresponsible for managing the client's care. **PURPOSE** To ensure thatthere is an	2022-09-01

	An undated agency job description titled "Registered Nurse" stated, "... Nursing assessment forms are completed ... [patient] conditions are assessed in every home visit ... documentation is done ...." An undated agency policy titled "Medication Administration Record (MAR" stated, "... It is required that the agency provide a medication administration record (MAR) for each patient that receive [sic] medications administered directly by a licensed nurse ... All nursing staff is required to document ... dose ... route ...." An undated agency policy titled "Physician Orders/Plan of Care" stated, "... Copies of the plan of care and other orders requiring a physician's signature should be filed in the patient record ...." An undated agency policy titled "Timeliness and Accuracy of Entries in the Clinical Record" stated, "... Each entry ... must be current, accurate ,,, must include all services ... Complete ... on the date service is rendered ...." A home visit occurred on 6/08/2022 at 1:00 PM with patient #1 and LPN 1. When queried how long she was assigned to this patient, LPN 1 indicated she has cared for this patient for 17 years (at this agency). When queried to describe her duties, LPN 1 indicated she administered medications throughout the day, fed the patient meals prepared by family (Orally and supplements via g-tube) (a tube inserted directly into the stomach for administration of nutrition, fluids, and/or medications), provided incontinence care as needed, showered the patient twice weekly, and cared for the patient's g-tube, which included cleansing, application of an ointment, and a gauze dressing. Observed LPN 1 provide incontinence care, and cleanse/dress the g-tube site. During this time, LPN indicated she saw the patient 5 days per week, from 8:00 AM - 6:00 PM. Observed a schedule posted on		accurate record of the services provided, client response andongoing need for care. To documentconformance with the Plan of Care, modifications to the plan, andinterdisciplinary involvement. **SPECIAL INSTRUCTIONS** 1. All skilled services provided byNursing, Therapy, or Social Services will be documented in the clinical record. 2. A separate note shall becompleted for each visit/shift and signed and dated by the appropriateprofessional. Actual time and length of the client visit will be included ineach note. 3. Additional information that ispertinent to the client's care or condition may be documented on the ProgressNote or Flow Sheet. 4. Telephone or other communication withclients, physicians/allowed non-physician practitioner (NPP), families, orother members of the health care team will be documented in clinical progressnotes or other	

	the inside of the patient's cabinet, which included times for medication administration, oral/g-tube feedings, and supplemental g-tube fluids, to which the LPN indicated she performed during her visits. Clinical record for patient #1 was completed on 6/13/2022, start of care date 2/09/2022. An agency document dated and signed by LPN 1 on 6/8/2022 titled "Skilled Nursing Visit Note" failed to include documentation of any medications, food, fluids, or treatments administered by LPN 1, or assessment of the g-tube insertion site. During an interview on 6/13/2022 at 1:51 PM, when queried where nurses documented medications/fluids/nutrition they administered to patients, the alternate administrator indicated it would be in their visit notes. When queried if they would expect to see medications administered by the nurse in the visit notes, the administrator/clinical manager and alternate clinical manager both stated "Yes." A comprehensive assessment document dated 2/09/2022, titled OASIS ASSESSMENT DETAILS was completed by the agency s administrator/clinical manager. The document indicated the patient experienced pain, and reasons for hospitalization included pain management, but failed to include a comprehensive pain assessment was completed; and failed to indicate the patient s lung sounds, bowel sounds, last bowel movement, g-tube assessment (or presence of), diet, nutrition/hydration status, psychological/behavioral status, neurological status, mental status, functional limitations, musculoskeletal status, fall risk assessment, activities permitted, or equipment/supply needs were assessed/documented by the RN. During an interview on 6/13/2022 at 12:49 PM, when queried to describe the patient s		interagency communication form. 5. Documentation of services ordered onthe plan of care will be completed the day service is rendered and incorporatedinto the clinical record within seven (7) days after the care has beenprovided. 6. Services not provided and the reasonfor the missed visits will be documented and reported to the physician/allownon-physician practitioner Staff will receive in service training, and QAPI meeting review Administrator will monitor this policy: policy will be on-going	

	nutritional requirements, the administrator/clinical manager stated, Through her tube [g-tube]. When queried if the patient received any other route (oral) of nutrition, the clinical manager stated No. When queried to describe what she did during the comprehensive visit on 2/09/2022, the clinical manager stated, I do the OASIS part, check her meds, or anything that was different, then we generate the POC [plan of care]. When queried if the comprehensive document should be fully completed by the RN, the clinical manager stated Yes. When queried why she didn t assess vital signs, the clinical manager indicated the LPN (LPN 1) was there too, so she put it down . When queried why a comprehensive pain assessment wasn t completed (history of hospitalization for pain management and pain was identified during the assessment), the clinical manager indicated the patient hasn t been in the hospital for pain management, and when queried, she indicated the comprehensive assessment document may be incorrect. When queried why she didn t assess lung sounds, she stated, I m not sure. When queried why she didn t assess the patient s last bowel movement, she stated, I don t know . When queried why she didn t assess the patient s musculoskeletal status, she stated Because she can t walk. When queried if equipment/supplies should be assessed during the comprehensive assessment, she stated, Yes. 17-14-1(a)(1)(E) 17-14-1(a)(2)(B)			
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 observation, record review, and interview, the home health agency failed to	G0726	. Healthmasters has updated its Licensed Practical NurseSupervision policy: Healthmasters will monitor LPN supervision based on this policy.	2022-08-31

ensure nursing services were provided under the supervision of a registered nurse (RN) for 1 of 1 home visits observed with a licensed practical nurse (LPN) (#1).

Findings include:

An undated agency policy received 6/13/2022, titled "Nurse Supervision" stated, "... LPNs will be supervised at least every 30 days by a [sic] RN in the patient's home with or without the LPN present ...."

A home visit was conducted on 6/08/2022 at 1:00 PM with patient #1 and LPN 1. When queried, LPN 1 indicated she provided nursing visits 10 hours per day, 5 days per week.

Clinical record for patient #1 was completed on 6/13/2022, with start of care date 2/09/2022. The electronic medical record (EMR) evidenced a tab titled "Supervisory Visit Note", which failed to evidence any LPN supervisory visits were made since 8/08/2019 (prior to this admission).

During an interview on 6/06/2022 at 11:02 AM, when queried where LPN supervisory visits were documented in the EMR, the administrator/clinical manager indicated they were in a separate tab in the EMR ("Supervisory Visit Note").

During an interview on 6/13/2022 at 1:51 PM, when queried the last time this patient was seen by an RN, the administrator/clinical manager stated, "... Well it was me ... [directed question to alternate administrator] didn t they leave and go back to Mexico? ...." When queried when the last LPN supervisory visit occurred, the alternate administrator indicated the problem was she (administrator/clinical manager) wasn't listing it as a supervisory visit. No further information was provided.

Following this policy will prevent recurring needs for correction.

LICENSED PRACTICALNURSE SUPERVISION

POLICY

The Agencyshall provide Licensed Practical Nurse services under the direction and supervisionof a Registered Professional Nurse when services are indicated and ordered bythe physician. At least once annually, all Licensed Practical Nurses will besupervised directly while providing care.

PURPOSE

To providesupervision of the Licensed Practical Nurse as required by state/federalguidelines. To assure the quality of services provided by the LicensedPractical Nurse.

To insure theLicensed Practical Nurse is adhering to appropriate standards of practice andfollowing the direction of the Registered Nurse.

	17-14-1(a)(1)(J)		To assesscompetency in the clinical skill and provide opportunity for review of plan ofcare with direct input from the caregiver in the home. **SPECIAL INSTRUCTIONS** 1. The Nursing Supervisor or designatedRegistered Nurse will give the Licensed Practical Nurse direction for clientcare by way of the Care Plan *(see CarePlan Policy).* A copy of this written plan is to be left in the client'shome and revised periodically, as necessary. The original copy of this planwill be kept in the client's chart. 2. Supervisory visits of LicensedPractical Nurses will be made in the following manner: a. ARegistered Nurse must review the Nursing Care Plan with the Licensed PracticalNurse before the first Licensed Practical Nurse visit. b. The Registered Nurse supervisory visit may becompleted directly while the Licensed Practical Nurse is providing service tothe client or indirectly by alternating visits with the LPN and RN. If	

			health aide services, the LPN supervision may becompleted at the same time as the aide supervision. 3. Supervisory visits are to bedocumented in the client's chart. The client/caregiver will be notified of anychanges in care. 4. If the Care Plan is complex and/or theclient's condition is unstable, the Registered Nurse may supervise and instructthe Licensed Practical Nurse on the first day of the assignment in person andas often as necessary thereafter. a. LPNswill not routinely provide visits to clients with complex medical needs orthose requiring complex nursing judgments/assessments, or who require complexteaching. b. If the LPN has demonstrated competency in and is assignedto provide care to clients with complex needs, the Registered nurse willsupervise and instruct the LPN on the first day of assignment and as often asdeemed necessary thereafter.	

			5. The Nursing Supervisor or anotherstaff Registered Nurse will be readily available by telephone should the LicensedPractical Nurse need assistance. Aministrator will monitor this policy; policy will be on-going	
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 registered nurse (RN) provided a current, written HHA plan of care/aide care plan (see tag G798); failed to ensure the HHA provided services only as ordered by the physician (see tag G800); failed to ensure the RN made a supervisory visit (either by phone or on-site) at least every 60 days (see tag G814). This practice affected all agency patients who received only home health aide services. Findings include: The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the	G0750	Healthmasters has a low patient census this allowed us todischarge and re-admitted our patients on the same day, generating a new startof care, new plan of care generated from the oasis. All patients weredischarged and re-admitted on different days to accommodate their physiciansSchedule. This allowed healthmasters to start patients with new compliant start ofcare dates. Healthmasters has hired a RN assist with oasis and care plans. Healthmasters hired RN has Twenty years of home health careexperience,RN will be assigned to review and approve oasis timely completion,accurate completion, care plans, patient medication updates, physician contact,supervisory visits, and	2022-08-31

	Home Health Aide Services. 410 IAC 17-13-2(a)		PRN visits. Our low census will assist our New hired RNto complete Oasis, start of care timely, with initial assessment requirements.Our new hired RN will be part of Nursing staff to assist with our Oasis, plansof care, and newly formed review process, which includes the Administrator, andRN. The process will include, over- see for timely completion, check for accuracyof oasis, plans of care, medication checks, supervisory visits, andcommunications with the Physicians. Documentation of all Oasis, plans of care, contact withpatients Physicians, and supervisory visits will be documented in newly formed reviewreport form, which will be submitted to Broad of Directors for review. Healthmasters has updated its Licensed Practical NurseSupervision policy: Policy The agency shall provide licensed practical nurse servicesunder the direction and supervision of a registered professional nurse when	

			ordered by the physician. At least once annually. All licensed practicalnurses will be supervised directly while providing care. Purpose: To provide supervision of the licensed Practical Nurse asrequired by state/federal guidelines. To insure the quality of services provided by the licensed Practical Nurse. To insure the Licensed practical nurse is adhering to appropriatestandards of practice and following the directions of the Registered Nurse. To assess competency in the clinical skill and provideopportunity for review of plan of care with direct input from the caregiver Inthe home. Healthmasters has updated its Home Health Aide supervision Policy: Agency shall provide Home Health Aide services under thedirection and supervision of	

			when personal careservices are indicated and ordered by physician. The frequency of supervisionwill be in response to medicare regulations, agency policy and other state orfederal requirements. PURPOSE: to observe the aide while providing care to client,and to assess competency in basic skills as well as delegated nursing task. Inservicewill be conducted to re-educate all staff. Administrator will monitor this policy;on-going	
G0778	Documentation of inservice training 484.80(d)(2)	G0778	**IN-SERVICE EDUCATION/STAFFDEVELOP**	2022-09-01

	The HHA must maintain documentation that demonstrates the requirements of this standard have been met. Based on record review and interview, the home health agency failed to ensure it maintained documentation that demonstrated home health aides (HHAs) received at least 12 hours of in-service training during each 12-month period. Findings include: 1. An undated agency policy titled Certified Nurse Aide/Home Health Aide stated, ... Clinical Manager ... responsible for ... overseeing the home health aide visits ..... [HHA must] ... complete 12 hours of annual in-services ... [agency] must maintain documentation that demonstrates the requirements of this standard have been met 2. Employee record for HHA 1 was completed on 6/09/2022 at 3:20 PM. The record failed to include documentation of any in-services. 3. Employee record for HHA 2 was completed on 6/09/2022 at 3:35 PM. The record failed to include documentation of any in-services. 4. Employee record for HHA 3 was completed on 6/09/2022 at 3:04 PM. The record failed to include documentation of any in-services.		**MENT** **POLICY** In-servicetraining or continuing education programs will be provided and documented foremployees. Programs will be appropriate to their responsibilities and to themaintenance of skills necessary to care for Agency clients. Programsincorporate adult teaching and learning principles and may utilize variouseffective adult teaching methodologies. Direct carestaff are required to attend or produce evidence of having attended appropriatenumber of continuing education programs required by law and regulation tomaintain current license and/or certification. All staffmembers must attend or provide proof of having participated in mandatoryin-service programs. The mandatory in-service training programs include: · OSHA/BloodbornePathogens and Infection control	

	5. During an interview on 6/09/2022 at 3:40 PM, informed person 3 (human resource manager) the employee records for HHAs 1, 2, and 3 failed to include any documentation of in-services attended. When queried if there was a separate in-service book, person 3 indicated there was. Nothing further was submitted. 6. During an interview on 6/13/2022 at 4:08 PM, when queried if the surveyor could review the in-service book, the alternate administrator stated, We had one ... but I don t know where it is .... When queried when the last in-service occurred, the alternate administrator stated, I don t know ... a long time .... Nothing further was submitted. 17-14-1(k)		· Safety– personal and client/environmental · EmergencyManagement · Othersas designated by Agency, state or regulatory bodies **PURPOSE** To assureemployees delivering client care or service are provided with opportunities todevelop and expand their knowledge appropriate to their responsibilities and tothe maintenance of skills necessary to care for clients. To increasestaff knowledge base of work-related issues Maintain andimprove staff competency Are appropriateto the needs of client populations served by the agency **SPECIAL INSTRUCTIONS** 1. Allstaff members providing direct client care will attend in-service educationprograms annually. These programs will be based on identified staff needs.	

			2. TheDirector of Clinical Services or designee will establish an annual staffdevelopment calendar and assure that programs are offered as required. Ongoingprograms will be offered as new equipment is introduced, new procedures areperformed in the home setting, and/or new client populations are served. 3. Staffinput will be sought regarding topics presented and others needed. 4. Eachtherapeutic service provided by the agency will be represented by subjectcontent and through the agency at least once a year. 5. Recordson in-service education programs will be maintained and attendance will bedocumented.	

			6. Educationalprograms may be held in conjunction with vendors or other health careorganizations. Employees who attend staff development programs outside theagency and submit documentation of attendance to be included in the employee'spersonnel record. 7. Theagency will maintain the following documentation of in-service/staffdevelopment programs: a. Résuméor curriculum vitae of presenter. b. Programsubject, date, and content or summary. c. Copyof handouts. d. Programattendee names and titles. 8. If the agency is Medicare-certified ormust adhere to the Medicare Conditions of Participation, or as states require,Agency will comply with in-service education requirements for home health aides: a. Training must be provided	

			by or under the direction of aRegistered Nurse with two (2) years of nursing experience and at least one (1)year in home care. b. The Home Health Aide must completetwelve (12) hours per year either in lecture, video in-services, or in theclient home while providing care. 9. Allemployees must attend in-service programs determined by the agency to bemandatory for all staff. 10. At the discretion of the agency,employees may attend in-service programs during the course of their workday andwill be given time off with pay to attend such programs. 11. In-service not sponsored or authorizedby the agency may not be attended during the workday without the expressapproval of the agency. 12. Payment of registration fees andrelated expenses will be at the discretion of the agency with prior approvalfrom the appropriate supervisor. 13. When an employee is	

			a conference, convention, or training program directlyrelated to his/her working position, no leave shall be reported, and theemployee shall be considered as working. 14. The twelve (12)-hour-per-calendar-yearrequirement for Home Health Aide in-services may be pro-rated according to theemployee's date of hire and records maintained per calendar year. 15. Random surveys are conducted to obtainemployee feedback regarding learning needs and areas of professional interestwhen planning in-service education programs. 16. A report about employee competencyassessments and agency response to assure and maintain competence in staff issubmitted to the governing body annually. Heallthmasters will contract with RCTCLEARN STUDENT GUIDE, video in-service. This will correct any deficiency with this policy. this also prevent it from recurring.	

			Administrator will monitor this policy; policy will be on-going	
G0798	Home health aide assignments and duties 484.80(g)(1) 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 home health agency failed to ensure the registered nurse (RN) provided a current, written home health aide (HHA) plan of care/aide care plan for 5 of 5 patients who received HHA services (#2, 3, 4, 5, 6). Findings include: 1. An undated agency policy received 6/13/2022, titled Certified Nurse Aide/Home Health Aide stated, ... Clinical Manager ... responsible for ... overseeing the home health aide visits ..... Provide only those services written in the plan of care and received as written instructions from the registered nurse supervisor ... [agency] must maintain documentation that demonstrates the requirements of this standard have been met .... 2. Clinical record review for patient #2 was	G0798	The following policy will correct any deficiency: **HOME HEALTH AIDE CAREPLAN** **POLICY** A complete andappropriate Care Plan, identifying duties to be performed by the Home HealthAide, shall be developed by a Registered Nurse or Therapist. All home healthaide staff will follow the identified plan. The Care Plan will be available toall persons involved in client care, including contracted providers. **PURPOSE** To provide ameans of assigning duties to the Home Health Aide that are clear to the Nurse,Home Health Aide, and to the client/caregiver being served. To providedocumentation that the supervising Nurse oriented the assigned Aide to theclient's care before initiating the care.	2022-08-31

	2/23/2013). The electronic medical record (EMR) included the most recent aide care plan, dated 10/28/2019. During an interview on 6/13/2022 at 3:25 PM, when queried why the aide care plan wasn t reviewed/updated since 10/28/2019, the alternate administrator questioned the surveyor if anything newer was in the EMR, to which the surveyor stated, No. When queried how often the agency was supposed to review/update the aide plan of care, the alternate administrator indicated it should be reviewed/updated when they did the OASIS (outcome assessment and information set), or every 56-60 days. When queried if they recalled the last time the aide care plan was reviewed, both the alternate administrator and clinical manager indicated they were not sure. When queried the last time she saw this patient (#2), the clinical manager stated, I m not sure. 3. Clinical record review for patient #3 was completed on 6/13/2022 (start of care date 4/22/2013). The EMR included the most recent aide care plan, dated 7/20/2019. During an interview on 6/13/2022 at 3:43 PM, when queried if the most recent aide care plan was dated 7/20/2019, the clinical manager stated, Yes. When queried if she remembered the last time she saw patient #3, the clinical manager stated, No. 4. Clinical record review for patient #4 was completed on 6/13/2022 (start of care date 4/08/2008). The EMR included the most recent aide care plan, dated 8/09/2019. During an interview on 6/13/2022 at 3:57 PM, when queried if there was an update aide plan of care after 8/09/2019, the alternate administrator indicated there was not.		To providedocumentation that the client's care is individualized to his/her specificneeds. **SPECIAL INSTRUCTIONS** 1. Following the initial nursing assessment andconsultation with the client/caregiver, a written plan identifying personalcare and supportive care services are prepared by a Registered Nurse orTherapist, as appropriate. 2. The CarePlan shall be developedin plain, non-technical lay terms and identify the duties to be performed suchas, but not limited to: a. Personalcare. b. Ambulationand exercise. c. Householdservices essential to health care at home. d. Assistancewith medications that are ordinarily self-administered. e. Mealplanning and preparation when supportive of health maintenance and promotion. 3. The Home Health Aide shall	

	5. Clinical record review for patient #5 was completed on 6/13/2022 (start of care date 3/18/2017). The EMR included the most recent aide care plan, dated 9/04/2019. During an interview on 6/13/2022 at 3:55 PM, when queried if there was an update aide plan of care after 9/04/2019, the alternate administrator indicated there was not. 6. Clinical record review for patient #6 was completed on 6/13/2022 (start of care date 12/08/2016). The EMR included the most recent aide care plan, dated 7/26/2019. During an interview on 6/13/2022 at 3:47 PM, when queried if there was an update aide plan of care after 7/26/2019, the alternate administrator indicated there was not. 17-13-2(a)		be assignedto a particular client by a Registered Nurse/Therapist after orders areobtained from the physician/allowed non-physician practitioner (NPP) as to theplacement of the Home Health Aide and frequency of visits. 4. Prior to initiating care, the HomeHealth Aide shall be oriented by a Registered Nurse/Therapist, by phone or inperson, to the client's care needs and shall be updated on modifications orchanges in the client's care. The orientation will include any specificobservations the home health aide is expected to report and document withparameters for reporting. 5. On-site orientation and returndemonstration of skills will be done as determined by client/caregiver request,client needs, or assessment of the Nurse/Therapist. 6. If the Home Health Aide is assigned toperform delegated nursing functions, such as administering medications, i.e.,eye drops, the Home Health	

			procedure by aRegistered Nurse and the nurse must document return demonstration and/or otherevidence of competency. 7. The Home Health Aide cannot beresponsible for performing any procedure that is not assigned to him/her inwriting by the Registered Nurse/Therapist or that is beyond his/her ability.The Home Health Aide tasks must be related to the physical care needs of theclient; he/she should not be assigned to solely homemaker tasks unless thoseservices are authorized by the payer source or the client is willing to payprivately for these services. 8. The Home Health Aide Care Plan shallbe reviewed and updated by the Registered Nurse minimally every sixty (60)days. 9. Home health aides must be members of the interdisciplinary team, must reportchanges in client's condition to a registered nurse or other appropriateskilled professional and must complete appropriate records in compliance withthe	

			procedures. 10. The original Care Plan shall be filedin the clinical record. A copy of the Care Plan shall be placed in the client'shome. This policy will prevent recurring deficiency; Administrator will Monitor this policy; policy will be on-going	
G0814	Non-skilled direct observation every 60 days 484.80(h)(2) If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the registered nurse must make an on-site visit to the location where the patient is receiving care no less frequently than every 60 days in order to observe and assess each aide while he or she is performing care. Based on record review and interview, the home health agency failed to ensure the registered nurse (RN) made a supervisory visit (either by phone or on-site) at least every 60 days for 5 of 5 clinical records reviewed with patients who received only home health aide (HHA) services (#2, 3, 4, 5, 6). Findings include: 1. An undated agency policy titled Nurse	G0814	Healthmasters has updated its Home Health Aide supervision policy to assure correction of any deficiency. Policy: **HOME HEALTH AIDE CAREPLAN** **POLICY** A complete andappropriate Care Plan, identifying duties to be performed by the Home HealthAide, shall be developed by a Registered Nurse or Therapist. All home healthaide	2022-09-01

	Supervision stated, ... If home health aide services are provided to a patient who is not receiving skilled nursing care ... the registered nurse shall make a supervisory visit to the patient s residence ... at least every 60 days .... 2. Clinical record review for patient #2, a HHA only patient, was completed on 6/13/2022 (start of care date 2/23/2013). An electronic medical record (EMR) document titled Home Health Plan of Care & Certification for certification period 7/16/2020 to 9/13/2020 indicated the patient received HHA services 3 times per week for 1-24 hours each visit, to help with personal care, and skilled nursing to evaluate HHA supervision every 30 days. The EMR also evidenced the most recent aide supervisory visit was conducted 7/14/2019. During an interview on 6/13/2022 at 3:25 PM, When queried if an aide supervisory visit occurred after 7/14/2019, the alternate administrator stated No. When queried when the last time an RN saw this patient (#2), the clinical manager stated, I m not sure. 3. Clinical record review for patient #3, a HHA only patient, was completed on 6/13/2022 (start of care date 4/22/2013). An EMR document titled Home Health Plan of Care & Certification for certification period 3/16/2020 to 5/14/2020 indicated the patient received HHA services 3 times per week for 1-24 hours each visit, and skilled nursing to assess and evaluate HHA performance (no frequency). The EMR also evidenced the most recent aide supervisory visit was conducted 7/20/2019. During an interview on 6/13/2022 at 3:43 PM, when queried when queried if she remembered the last time she saw this patient (#3), the clinical manager stated, No. 4. Clinical record review for patient #4, a HHA only patient, was completed on 6/13/2022 (start of care date 4/08/2008). An EMR		staff will follow the identified plan. The Care Plan will be available toall persons involved in client care, including contracted providers. **PURPOSE** To provide ameans of assigning duties to the Home Health Aide that are clear to the Nurse,Home Health Aide, and to the client/caregiver being served. To providedocumentation that the supervising Nurse oriented the assigned Aide to theclient's care before initiating the care. To providedocumentation that the client's care is individualized to his/her specificneeds. **SPECIAL INSTRUCTIONS** 1. Following the initial nursing assessment andconsultation with the client/caregiver, a written plan identifying personalcare and supportive care services are prepared by a Registered Nurse orTherapist, as appropriate. 2. The CarePlan shall be developedin plain, non-technical lay terms and	

	document titled Home Health Plan of Care & Certification for certification period 3/26/2022 to 5/24/2022 indicated the patient received HHA services 8 hours per day (not specified how many days per week). The EMR also evidenced the most recent aide supervisory visit was conducted 9/02/2019. During an interview on 6/13/2022 at 3:57 PM, when queried when she last saw the patient, the clinical manager stated, Maybe a month ... 2 months .... , and the alternate administrator indicated the patient was only seen by a HHA now. When queried if there were any aide supervisory visits after 9/02/2019, the alternate administrator stated, No. 5. Clinical record review for patient #5, a HHA only patient, was completed on 6/13/2022 (start of care date 3/18/2017). An EMR document titled Home Health Plan of Care & Certification for certification period 2/20/2022 to 4/20/2022 indicated the patient received HHA services 6 hours per day, 7 days per week); and skilled nursing every 30 days (not further specified), and every 56-60 days (not further specified). The EMR also evidenced the most recent aide supervisory visit was conducted 9/01/2019. During an interview on 6/13/2022 at 3:55 PM, when queried when she last saw the patient, the clinical manager stated, I can t remember. When queried if an RN completed an aide supervisory visit after 9/01/2019, the alternate administrator stated, No. 6. Clinical record review for patient #6, a HHA only patient, was completed on 6/13/2022 (start of care date 12/08/2016). An EMR document titled Home Health Plan of Care & Certification for certification period 3/17/2021 to 5/15/2021 indicated the patient received HHA services 6 hours per day, 5 days per week); and skilled nursing every 30 days (not further specified), and every 56-60 days to assess and evaluate. The EMR also evidenced the most recent aide supervisory visit was		identify the duties to be performed suchas, but not limited to: a. Personalcare. b. Ambulationand exercise. c. Householdservices essential to health care at home. d. Assistancewith medications that are ordinarily self-administered. e. Mealplanning and preparation when supportive of health maintenance and promotion. 3. The Home Health Aide shall be assignedto a particular client by a Registered Nurse/Therapist after orders areobtained from the physician/allowed non-physician practitioner (NPP) as to theplacement of the Home Health Aide and frequency of visits. 4. Prior to initiating care, the HomeHealth Aide shall be oriented by a Registered Nurse/Therapist, by phone or inperson, to the client's care needs and shall be updated on modifications orchanges in the client's care. The orientation will	

	conducted 6/20/2019. During an interview on 6/13/2022 at 3:47 PM, when queried when she last saw the patient, the clinical manager stated, I don t remember. When queried if an aide supervisory visit was conducted after 6/20/2019, the alternate administrator stated, No.		include any specificobservations the home health aide is expected to report and document withparameters for reporting. 5. On-site orientation and returndemonstration of skills will be done as determined by client/caregiver request,client needs, or assessment of the Nurse/Therapist. 6. If the Home Health Aide is assigned toperform delegated nursing functions, such as administering medications, i.e.,eye drops, the Home Health Aide must be oriented to the procedure by aRegistered Nurse and the nurse must document return demonstration and/or otherevidence of competency. 7. The Home Health Aide cannot beresponsible for performing any procedure that is not assigned to him/her inwriting by the Registered Nurse/Therapist or that is beyond his/her ability.The Home Health Aide tasks must be related to the physical care needs of theclient; he/she should not be assigned to solely	

			thoseservices are authorized by the payer source or the client is willing to payprivately for these services. 8. The Home Health Aide Care Plan shallbe reviewed and updated by the Registered Nurse minimally every sixty (60)days. 9. Home health aides must be members of the interdisciplinary team, must reportchanges in client's condition to a registered nurse or other appropriateskilled professional and must complete appropriate records in compliance withthe agency's policies and procedures. 10. The original Care Plan shall be filedin the clinical record. A copy of the Care Plan shall be placed in the client'shome. this policy will prevent any recurring deficiency. Policy will be monitored by the Administrator; policy will be on-going	
G0940	Organization and administration of services	G0940	Healthmasters,Inc has	2022-09-01

	484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. Based on record review and interview, the agency's governing body failed to provide responsibility of the agency's overall management and operation, including the development/maintenance of operational policies/procedures, the emergency preparedness program, and its quality assessment and performance improvement (QAPI) program (see tag G942); the agency's administrator failed to be responsible for the day-to day operations of the agency (see tag G948); failed to ensure the clinical manager was available during all operating hours (see tag G950); and the clinical manager failed to provide direct oversight/assignment of staff and patient schedules (see tag G960). This practice affected all agency patients. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR §484.105: Organization and Administration of Services		conducted QAPI meetings with staff,but failed to document the meeting with written minutes. Several meetingscovered the following: 1. Covid 19 topic and precautions, 2. Vaccination for Covid19, 3. Staff requirements for employment 4. Distribution of Covid 19 protectionequipment. Staff were issued the following protective equipment: 1. Gowns (fully covered torso from neck to knees,arm to end of wrists and wraps around the back, fasten in back of neck andwaist). 2. Mask and respirators 3. Goggles and face shield 4. Gloves. In meetinginstructive demo was given on use of equipment. All of our employees are fully vaccinated ,for Covid 19 and copiesof vaccination cards are in our employee health files. All of our patients arefully vaccinated With our addition to the RN staffing, our committee willbegan documenting all QAPI related meeting , and forwarded to the Broad of Directorsfor review. Healthmasters has been no	

			exception to Covid-19, affects onour job market environment. We, however see the job market improving, and lookforward to bring on clerical workers to assist with are clerical back load. QAPI,is the one area of our Governing Body requirements affected, however , weexpect to show strong improvement by the of this quarter. Our emergency preparedness program is another area where documentation needs to improve, we are however,providing emergency preparedness efforts to all of our patient. We will improvedocumentation by the end of the quarter. Administrator will be responsible. The meetings will be ongoing	
G0942	Governing body 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall	G0942	Healthmasters has been no exception to Covid-19, affects onour job market environment. We, however see the job market improving, and lookforward to	2022-08-31

	all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on record review and interview, the agency's governing body failed to provide responsibility of the agency's overall management and operation, including the development/maintenance of operational policies/procedures, the emergency preparedness program, and its quality assessment and performance improvement (QAPI) program. Findings include: An undated agency policy received 6/07/2022, titled "Administrative Control" indicated the governing body was responsible for the agency's overall management and operation, the QAPI program, the review and approval of new policies/procedures at least annually, and governing body meetings must be held at least monthly. During an interview on 6/6/2022 at 11:02 AM, when queried who the members of the governing body were, the alternate administrator indicated he and the administrator/clinical manager were the members of the governing body. During an interview on 6/10/2022 at 11:00 AM, when queried to submit the agency s QAPI program and governing body meeting minutes for review, the alternate administrator indicated there was nothing to submit, and it was very far behind. Upon survey exit, no further information was provided or submitted for review. During an interview on 6/13/2022 at 11:37 AM, when queried when the last time the emergency preparedness program/plan was reviewed, person 4 (emergency preparedness manager) indicated it was about 3 years ago, nothing has been done at all since COVID-19		bring on clerical workers to assist with are clerical back load. The following policy will assure the Governing body will assume all functioning responsibility of Healthmasters,Inc. **GOVERNING BODY** **POLICY** The Governing Body (or designated persons so functioning)shall assume full legal authority and responsibility for the overall managementand operation of Agency. This includes the provision of home health services,fiscal operations, review of the agency’s budget and its operational plans aswell as the Quality Assessment and Performance Improvement Program. New governing body members/designees are oriented to theagency as appropriate to responsibilities. The roles of the Governing Body maynot be delegated. **PURPOSE** To providedirection and	

	started, and the agency didn't have anything (implemented) for COVID-19. The alternate administrator, a member of the governing body, was present during this interview. 410 IAC 17-12-1(b)		supervision of the agency's operation and services. To ensure linesof authority are established. Toensure clients are provided with appropriate, quality services. **SPECIAL INSTRUCTIONS** The duties andresponsibilities of the Governing Body shall include: 1. Appointa qualified Administrator. Delegate to that individual the authority andresponsibility for the day to day operations of the agency to include provisionof home care services in accordance with state and federal regulations,accreditation standards, and Agency mission. 2. TheAdministrator or a pre-designated person is available during all operatinghours. The backup person assumes theadministrator's responsibilities and obligations when acting in that role. This position must be approved by the GoverningBody. Available means physically presentin the	

			office or able to be contacted by telephone or other electronic means. 3. Approvesthe Clinical Manager who will provide oversight of all patient care servicesand personnel, and is available during all operating hours. 4. Providedirection and leadership and be directly involved in the agency's QualityAssessment and Performance Improvement Program (QAPI). 5. Adoptand periodically review and approve the administrative and personnel policies,client care policies and procedures, bylaws as required by state licensureregulations, the annual operating budget, and capital expenditure plan. 6. Overseethe management and fiscal affairs of the agency. This shall include budgetpreparation and reviewing/monitoring financial information and organizationaloperations.	

			7. Definethe corporate structure and clearly indicate lines of authority. 8. Implementa Conflict of Interest policy. 9. Providefor proper licenses and insurance liability coverage. this policy will be monitored by the President/CEO; this policy will be on-going	
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the agency's administrator failed to be responsible for the day-to day operations of the agency. Findings include: An undated agency policy received 6/07/2022, titled Administrative Control stated, ... alternate [administrator] ... to act in the absence of the Administrator ... At a minimum, the Administrator ... must ... Manage the daily operations of the agency .... The administrator failed to ensure the day-to-day operations of the home health agency as evidenced by:	G0948	Healthmasters Administrator brings over Thirty-five (35) years experience in Nursing. Our Administrator is a RNBSN/MSN, with twenty-nine (29) years as Healthmaster's, Administrator. Our systemic changes will involve hiring additional nursing staff, to delegate responsibility. **The following policy will ensure that our Administrator will be responsible for day to day activities.** **GOVERNING BODY** **POLICY**	2022-07-29

	The administrator failed to ensure there was a current Emergency Preparedness Program in place for the home health agency. Please see tag E-0001, Condition of Participation 42CFR §484.102: Emergency Preparedness, and the additional tags associated with this federal regulation. The administrator failed to ensure each patient received, or the agency provided, comprehensive assessment(s)/reassessment(s). Please see tag G510, Condition of Participation 42CFR §484.55: Comprehensive Assessment of Patients, and the additional tags associated with this federal regulation. The administrator failed to ensure the agency developed and implemented an effective discharge planning process in accordance with the Condition of Participation 42CFR §484.58: Discharge Planning. Please see tag G560, and the additional tags associated with this federal regulation. The administrator failed to ensure each patient received an individualized written plan of care, which included any revisions or additions. Please see tag G570, Condition of Participation 42CFR §484.60: Care Planning, Coordination of Services, and Quality of Care, and the additional tags associated with this federal regulation. The administrator failed to ensure the agency developed, implemented, evaluated, or maintained an effective, ongoing, agency-wide, data-driven quality assessment and performance improvement QAPI program. Please see tag G640, Condition of Participation 42CFR §484.65: Quality Assessment and Performance Improvement (QAPI). The administrator failed to ensure the agency maintained and documented an infection control program, which also included		The Governing Body (or designated persons so functioning)shall assume full legal authority and responsibility for the overall managementand operation of Agency. This includes the provision of home health services,fiscal operations, review of the agency's budget and its operational plans aswell as the Quality Assessment and Performance Improvement Program. New governing body members/designees are oriented to theagency as appropriate to responsibilities. The roles of the Governing Body maynot be delegated. **PURPOSE** To providedirection and supervision of the agency's operation and services. To ensure linesof authority are established. Toensure clients are provided with appropriate, quality services. **SPECIAL INSTRUCTIONS** The duties andresponsibilities of	

	compliance with the COVID-19 vaccine mandate requirement. Please see tag G680, Condition of Participation 42CFR §484.70: Infection Prevention and Control, and the additional tags associated with this federal regulation. The administrator failed to ensure home health aide (HHA) services were provided in accordance with the Condition of Participation 42CFR §484.80: Home Health Aide Services. Please see tag G750, and the additional tags associated with this federal regulation. The administrator failed to ensure the clinical manager was available during all operating hours (please see tag G950). The administrator failed to ensure her availability during all operating hours (please see tag G956). The administrator failed to ensure the clinical manager provided oversight of all patient care services and personnel (please see tag G958). The administrator failed to ensure the clinical manager provided direct oversight/assignment of staff and patient schedules (please see tag G960). The administrator failed to ensure the clinical manager ensured patient needs were continually assessed (please see tag G966). The administrator failed to ensure the clinical manager developed, implemented, and updated the individualized plans of care (please see tag G968). The administrator failed to ensure the agency maintained patient clinical records in		the Governing Body shall include: 1. Appointa qualified Administrator. Delegate to that individual the authority andresponsibility for the day to day operations of the agency to include provisionof home care services in accordance with state and federal regulations,accreditation standards, and Agency mission. 2. TheAdministrator or a pre-designated person is available during all operatinghours. The backup person assumes theadministrator's responsibilities and obligations when acting in that role. This position must be approved by the GoverningBody. Available means physically presentin the office or able to be contacted by telephone or other electronic means. 3. Approvesthe Clinical Manager who will provide oversight of all patient care servicesand personnel, and is available during all operating hours. 4. Providedirection and leadership and be directly	

	accordance with the Condition of Participation 42CFR §484.110: Clinical Records. Please see tag G1008, and the additional tags associated with this federal regulation. 410 IAC 17-12-1(b)(3) 410 IAC 17-12-1(c)(1)		involved in the agency's QualityAssessment and Performance Improvement Program (QAPI). 5. Adoptand periodically review and approve the administrative and personnel policies,client care policies and procedures, bylaws as required by state licensureregulations, the annual operating budget, and capital expenditure plan. 6. Overseethe management and fiscal affairs of the agency. This shall include budgetpreparation and reviewing/monitoring financial information and organizationaloperations. 7. Definethe corporate structure and clearly indicate lines of authority. 8. Implementa Conflict of Interest policy. 9. Providefor proper licenses and insurance liability coverage. policy will correct any deficiency, and prevent any recurring deficiency. The President/CEO will be	

			policy; policy will be on-going.	
G0950	Ensure clinical manager is available 484.105(b)(1)(iii) (iii) Ensure that a clinical manager as described in paragraph (c) of this section is available during all operating hours; Based on record review and interview, the home health agency failed to ensure the clinical manager was available during all operating hours. Findings include: An undated agency policy titled "Administrative Control" indicated the administrator or alternate, and the clinical manager or alternate would be available during the agency's operating hours, either in person or by telephone. On Tuesday, 5/31/2022, the surveyor arrived to the agency at 10:30 AM. The door was locked, and no one answered to several knocks. The interior was visible from the glass door, and no lights were on. There was a sign posted on the window, which stated "... If you need immediate assistance call (219) 762-0004 ...." On 5/31/2022 the surveyor called (219) 762-0004 at 10:34 AM, 10:35 AM, and 10:36 AM. The calls went directly to a recorded message, which failed to indicate the number called was Healthmasters, Inc., indicated the voicemail box was full, and there was no option to leave a message for a return call. On 5/31/2022 at 11:20 AM, the surveyor	G0950	Healthmasters following policy will assure our clinical Manager will be Available for all hours of operations. **CLINICALMANAGER** **POLICY** Agency will appoint one or more qualifiedindividuals for the position of clinical manager. This position provides clinical oversightover all client care services and staff. The position must have at least one of thefollowing qualifications: licensed physician, registered nurse-including anurse practitioner or other advance practice nurse, physical therapist,speech-language pathologist, occupational therapist, social worker oraudiologist. **PURPOSE** To provide oversight of agency personnel toassure coordinated	2022-09-01

	emailed the administrator at "rozzilov@gmail.com", in attempt to make contact. No return email was received. On 5/31/2022 at 12:17 PM, the surveyor returned to the agency, to find no one there. On 5/31/2022 at 2:23 PM, the surveyor called (219) 762-0004. Again, the calls went directly to a recorded message, which failed to indicate the number called was Healthmasters, Inc., indicated the voicemail box was full, and there was no option to leave a message for a return call. On 6/01/2022 at 2:27 PM, the surveyor received a call from (219) 742-3444. The callers identified themselves (administrator/clinical manager) and alternate administrator) They indicated they were closed for the "holiday" on Monday, 5/30/2022 and Tuesday, 5/31/2022. On Wednesday, 6/08/2022 at 2:17 PM, the surveyor called the agency. The call went directly to a recorded message, which failed to indicate the number called was Healthmasters, Inc., indicated the voicemail box was full, and there was no option to leave a message for a return call. On Friday, 6/10/2022 at 9:35 AM, the surveyor called the agency 3 times in a row. The calls went directly to a recorded message, which stated "We're sorry, you have reached a number that has been disconnected or is no longer in service." On 6/10/2022 at 9:30 AM, informed the administrator/clinical manager, the alternate administrator, and person 3 (human resource manager) of the phone messages that it was disconnected, to which the alternate administrator indicated the phone carrier was going to get them "shut down".		comprehensive care to clients. To coordinate referrals and client carebetween disciplines and physicians. To assure the development, implementation,and updates of the individualized plan of care. **SPECIALINSTRUCTIONS** 1. Thisposition may be held by one or more individuals, but it is specific positionwith specific responsibilities. The appointments will be made by the GoverningBody or their designee(s). 2. Theorganizational structure for each agency will vary and will be set forth inpolicies and procedures. As long as the responsibilities are fulfilled, thereis flexibility in how they implement the clinical manager role. 3. Clinical,management, and communication skills are needed to successfully complete theresponsibilities. 4. Theoversight provided by the clinical manager(s) includes:	

	410 IAC 17-12-1(d)		a. Makingclient and personnel assignments. b. Coordinatingclient care. c. Coordinatingreferrals. d. Assuringthe client needs are continually assessed. e. Assuringthe development, implementation, and updates to the individualized plans ofcare. 5. Thisrole may be several managers who divide up the caseload, and each manager isresponsible for assuring that all functions needed by their caseload arefulfilled. 6. Theclinical manager is responsible for assuring that supervision is doneappropriately, but it is not required that they must directly supervise butagency will determine if this task is performed or delegated by the clinicalmanager. 7. Itis NOT recommended that the Administrator also assume the role of the clinicalmanager. Healthmasters has contacted with Medical Exchange Answering Service Inc,	

			willoperate when ever our office phone are off line. Staff and patients haveadministrator' cell phone number and have 24hour 7day/wk access to bothadministrator/alternate: which will prevent the phones from being not answered. the alternate Administrator monitor this policy; policy will be on-going	
G0960	Make patient and personnel assignments, 484.105(c)(1) Making patient and personnel assignments, Based on record review and interview, the clinical manager failed to provide direct oversight/assignment of staff and patient schedules. Findings include: An undated agency policy titled "Administrative Control" stated "... The Clinical Manager shall ... Making patient and personnel assignments ...." On 6/06/2022 at 11:55 AM, surveyor requested a list of all patients scheduled for home visits during the survey, to include date/time of visit, staff name with discipline assigned, and location of patient (city). On 6/09/2022, the alternate administrator submitted an undated document titled	G0960	this policy will correct the deficiency of concerns for oversight by our clinical Manager. **CLINICALMANAGER** **POLICY** Agency will appoint one or more qualifiedindividuals for the position of clinical manager. This position provides clinical oversightover all client care services and staff. The position must have at least one of thefollowing qualifications: licensed physician, registered nurse-including anurse practitioner or other advance practice nurse, physical	2022-09-02

	6, but failed to include patient #1 and 7's scheduled visits. During an interview on 6/07/2022 at 11:57 AM, when queried about patient #7's current disposition, the clinical manager indicated patient #7 was currently discharged, and was in Mexico with family. During an interview on 6/13/2022 at 4:00 PM, when queried about patient #7's current disposition, the clinical manager indicated patient #7 was readmitted about a week and a half ago (on or about 6/01/2022). When queried who readmitted him, the clinical manager indicated RN 2 did. Patient #7's clinical record indicated he was readmitted on 5/20/2022. During an interview on 6/13/2022 at 1:51 PM, when queried the last time patient #1 was seen by an RN, the clinical manager stated. "Well it was me ... didn t they leave and go back to Mexico [query directed to alternate administrator]?" The alternate administrator indicated the last RN visit would have been in April (2022). 410 IAC 17-14-1(a)(1)(K)		therapist,speech-language pathologist, occupational therapist, social worker oraudiologist. **PURPOSE** To provide oversight of agency personnel toassure coordinated comprehensive care to clients. To coordinate referrals and client carebetween disciplines and physicians. To assure the development, implementation,and updates of the individualized plan of care. **SPECIALINSTRUCTIONS** 1. Thisposition may be held by one or more individuals, but it is specific positionwith specific responsibilities. The appointments will be made by the GoverningBody or their designee(s). 2. Theorganizational structure for each agency will vary and will be set forth inpolicies and procedures. As long as the responsibilities are fulfilled, thereis flexibility in how they implement the clinical manager role. 3. Clinical,management, and	

			communication skills are needed to successfully complete theresponsibilities. 4. TheOVERSIGHT provided by the clinical manager(s) includes: a. Makingclient and personnel assignments. b. Coordinatingclient care. c. Coordinatingreferrals. d. Assuringthe client needs are continually assessed. e. Assuringthe development, implementation, and updates to the individualized plans ofcare. 5. Thisrole may be several managers who divide up the caseload, and each manager isresponsible for assuring that all functions needed by their caseload arefulfilled. 6. Theclinical manager is responsible for assuring that supervision is doneappropriately, but it is not required that they must directly supervise butagency will determine if this task is performed or delegated by the clinicalmanager.	

			7. Itis NOT recommended that the Administrator also assume the role of the clinicalmanager. the policy will prevent any recurring deficiency. the Alternate Administrator will monitor this policy and concerns; policy will be on-going	
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's clinical record contained a current comprehensive assessment, all of the assessments from the most recent home health admission, or plans of care that were signed by the certifying physician (see tag G1012); failed to ensure the patient's clinical record was updated to include the physician's contact information (see tag G1020); failed to ensure all clinical documents were current, accurate, complete, dated, and timed (see tag G1024); and failed to ensure all patients	G1008	Healthmasters has updated a policy for ClinicalDocumentation: POLICY: Healthmasters will document each direct contact with theclient. The documentation will be completed by the direct caregivers andmonitored by the skill professional responsible for managing the client' care. PURPOSE: To ensure that there is an accurate record of the servicesprovided, clients response and ongoing need for care. To document conformance with the plan of care,	2022-09-01

	clinical records were safeguarded against loss or unauthorized use (see tag G1028). Findings include: The cumulative effect of these systemic problems resulted in the home health agency being found out of compliance for the Condition of Participation 42 CFR §484.110: Clinical Records.		modificationsto the plan, and interdisciplinary involvement. All skilled services provided by nursing, therapy, or socialservices will be document In the clinical record A separate note shall be completed foe each visit/shift andsigned and dated by the appropriate professional. Actual time and length of theclients visit will be included in each note. Additional information that is pertinent to the client'scare or condition may be documented on the progress note or flow sheet. Telephone or other communication with clients,physicians/allowed non-physicians practitioner, families, or other member ofthe health care team will be documented in clinical progress notes or otherinteragency interagency communication form. Documentation of services ordered on the plan of care will be completed the day service is	

			rendered andincorporated into the clinical record within seven(7) days after the care hasbeen provided Services not provided and the reason for the missed visitwill be documented and reported to the physician/allowed non-physicianpractitioner. Staff will be inserviced concerning missed documentation for clientservices and healthmasters policy concerning clinical Documentation. Phone numbers for theAdministrator, and supervisor will be kept in patient admit packet in home,also a schedule of services ,and .staff assigned to case with phone number. Administrator will be responsible for monitoring thispolicy, and this will be on-going	

G1012	Required items in clinical record 484.110(a)(1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders; Based on record review and interview, the home health agency failed to ensure the patient's clinical record contained a current comprehensive assessment, all of the assessments from the most recent home health admission, or plans of care that were signed by the certifying physician, for 7 of 7 records reviewed (#1, 2, 3, 4, 5, 6, 7). Findings include: 1. An undated agency policy titled "Physician Orders/Plan of Care" stated "... Copies of the plan of care and other orders requiring a physician's signature should be filed in the patient's record within 3 days of receipt ...." 2. An undated agency policy titled "Timeliness and Accuracy of Entries in the Clinical Record" stated, "... Each entry into the patient's record must be ... signed ... Signed physician orders will be filed in the clinical record within 48 hours ...." 3. An undated agency policy titled Comprehensive Assessment of Patients (OASIS) [outcome assessment and information set] stated ... A comprehensive assessment ... will be performed ... not less frequently than every second month ...." 4. During an interview on 6/06/2022 at 11:02 AM, when queried how the agency maintained clinical records, the administrator and alternate administrator both indicated there were no	G1012	Healthmasters has brought our oasis assessments up to date, as of the last survey. We will follow this policy to the letter to maintain our up to date status. following this policy completely will prevent this deficiency from recurring. **COMPREHENSIVE CLIENTASSESSMENT** **POLICY** The initialassessment visit must be held either within 48 hours of referral or within 48hours of the client’s return home, or on the physician ordered start of caredate. A thorough,well-organized, comprehensive and accurate assessment, consistent with theclient’s immediate needs will be completed for all clients in a timely manner,but no later than five (5) calendar days after start of care. All skilledMedicare and Medicaid clients except pediatric and post-partum will havecomprehensive assessments that include the OASIS data set specific to mandatedtime points.	2022-08-26

	paper charts or clinical documents, and everything was located in the electronic medical record (EMR). 5.Clinical record for patient #1 was completed on 6/13/2022, (start of care date 2/09/2022), for certification period 4/10/2022 6/08/2022. The EMR failed to include a comprehensive reassessment or plan of care for the certification period that began on 6/09/2022, and failed to include plans of care with the physician's signature, for certification periods 2/09/2022 - 4/09/2022, and 4/10/2022 - 6/08/2022. During an interview on 6/06/2022 at 1:57 PM, when queried where the current plan of care with the physician s signature (for patient #1) was located in the EMR, the administrator and alternate administrator both indicated it was a paper copy, and not in the EMR. When queried on the location of the paper copy, the administrator indicated she thought she could find it. When queried if the paper copy was located on the premises, the administrator indicated she d look, and walked to the back of the office. During this time, the alternate administrator indicated if the document was not on the premises, he could get it. When queried where the document would be if not on the premises, the alternate administrator stated, We have them [clinical documents] at home as well. 6. Clinical record review for patient #2 was completed on 6/13/2022 (start of care date 2/23/2013). The EMR evidenced comprehensive re-assessment was completed on 11/20/2020, and the most recent completed plan of care was for certification period 1/18/2020 3/17/2020, which was not signed by the physician. During an interview on 6/13/2022 at 3:25 PM, when queried when the last time an RN saw this patient (#2), the clinical manager stated, I m not sure. When queried if an RN completed		For Medicareclients the agency must verify the client's eligibility for the home healthbenefit including homebound status, both at the time of the initial assessmentvisit and at the time of the comprehensive assessment. Theassessment identifies facilitating factors and possible barriers to clientreaching his or her goals including presenting problems. The depth andfrequency of ongoing assessments will depend on client needs, goals, and thecare treatment and services provided, but will be done at least once in everysixty (60) day period. Theinitial assessment bridges the gap between the first client encounter until aplan of care can be implemented. Thesemay include items such as the availability of medication, mobility aids forsafety, skilled treatments, fall risk measures and nutritional needs. **PURPOSE**	

	11/20/2020, the alternate administrator stated, ... No, I don t see any ... No, there s none. During an interview on 6/13/2022 at 3:25 PM, when queried if the EMR included a completed plan of care any time after 3/17/2020, the alternate administrator indicated there was not. 7. Clinical record review for patient #3 was completed on 6/13/2022 (start of care date 4/22/2013). The EMR evidenced the last comprehensive re-assessment was completed 7/11/2020, the most recent plan of care was for certification period 3/16/2020 5/14/2020, which was not signed by the physician. During an interview on 6/13/2022 at 3:43 PM, during EMR review, when queried if she remembered the last time she saw this patient (#3), the clinical manager stated, No. When queried if any comprehensive re-assessments were completed after 7/11/2020, the alternate administrator stated, No. During an interview on 6/13/2022 at 3:43 PM, when queried if the EMR included a completed plan of care any time after 5/14/2020, the alternate administrator indicated there was not. 8. Clinical record review for patient #4 was completed on 6/13/2022 (start of care date 4/08/2008). The EMR evidenced the last comprehensive re-assessment was completed 1/25/2022, and the last routine skilled nursing visit was 1/29/2021, and the most recent plan of care was for certification period 3/26/2022 5/24/2022, which was not signed by the physician. During an interview on 6/13/2022 at 3:57 PM, when queried when she last saw the patient, the clinical manager stated, Maybe a month ... 2 months .... When queried if a comprehensive		To determine the appropriate care, treatment and services to meet clientinitial needs and his/her changing needs. To collect data about the client's health history, physical, functionaland psychosocial and cognitive status) and their needs as appropriate to thehome care setting. To make care, treatment or service decisions based oninformation developed about each client's needs and the individual's responseto care. To increase clarity in measurement. To measure processes of care in the agency. To identify clients medical, nursing, rehabilitative, social anddischarge planning needs. Toverify eligibility for Medicare, Medicaid or other insurance benefit, asindicated and identify the need and coverage for home care services. **SPECIAL INSTRUCTIONS** 1. The Comprehensive Assessment will becompleted by a Registered Nurse, except in	

	re-assessment was completed after 1/25/2022, the alternate administrator stated, No .... During an interview on 6/13/2022 at 3:57 PM, when queried if the EMR included a completed plan of care any time after 5/22/2022, the alternate administrator indicated there was not. 9. Clinical record review for patient #5 was completed on 6/13/2022 (start of care date 3/18/2017). The EMR evidenced the last comprehensive re-assessment was completed 2/20/2022, and the most recent plan of care was for certification period 2/20/2022 4/20/2022, which was not signed by the physician. During an interview on 6/13/2022 at 3:53 PM, when queried when she last saw the patient, the clinical manager stated, I can t remember. When queried if an RN completed a comprehensive re-assessment after 2/20/2022, the alternate administrator stated, No. During an interview on 6/13/2022 at 3:50 PM, when queried if the EMR included a completed plan of care any time after 4/20/2022, the alternate administrator indicated there was not. 10. Clinical record review for patient #6 was completed on 6/13/2022 (start of care date 12/08/2016). The EMR evidenced the last comprehensive re-assessment was completed 7/15/2021, and the most recent plan of care was for certification period 3/17/2021 5/15/2021, which was not signed by the physician. During an interview on 6/13/2022 at 3:47 PM, when queried when she last saw the patient, the clinical manager stated, I don t remember. When queried if an RN completed a comprehensive re-assessment after 7/15/2021,		situations where therapy servicesare the only service ordered by the physician/allowed non-physicianpractitioner (NPP). When physical therapy, speech-language pathology, oroccupational therapy is the only service ordered by the physician or NPP who isresponsible for the home health plan of care, and if the need for that serviceestablishes program eligibility, the initial assessment may be made by theappropriate rehabilitation skilled professional. 2. When physical therapy, speech-languagepathology, or occupational therapy is the only service ordered by the physicianor allowed practitioner, the therapist may complete the comprehensiveassessment, and for Medicare clients, determine eligibility for the Medicarehome health benefit, including homebound status. The occupational therapist may complete thecomprehensive assessment if the need for occupational therapy establishesprogram eligibility. a. TheComprehensive	

	the alternate administrator stated, No. During an interview on 06/09/2022 at 12:40 PM, when queried why the patient had no plan of care after 5/2021, the alternate administrator indicated the patient didn t, and they would have to generate one for her as well. 11. Clinical record review for patient #7 was completed on 6/13/2022 (start of care date 5/20/2022). The EMR evidenced the most recent plan of care was for certification period 11/05/2021 to 1/03/2022, which indicated a start of care date of 5/20/2022, and did not include a plan of care for the re-admission on 5/20/2022, for certification period 5/20/2022 - 7/18/2022. During an interview on 6/13/2022 at 4:00 PM, when queried if the EMR included a plan of care for this admission (5/20/2022), the alternate administrator indicated there was not. 410 IAC 17-15-1(a)(1) - (7)		Assessment must accurately reflect the client's status, and mustinclude at a minimum, the following information: The client's current health,psychosocial, functional, and cognitive status. This includes an evaluation ofmental health and functional capacity within the community. Cognitiveassessment refers to the degree of client's ability to understand, remember andparticipate in developing and implementing a plan of care. b. Assessthe functional status and their ability to function independently in the homewith such activities as ADLs. c. Theclient's strengths, goals, and care preferences, including information that maybe used to demonstrate the client's progress toward achievement of the goalsidentified by the client and the measurable outcomes identified by the agency.Intent is to engage the client to take an active role in their home care. d. Theclient's continuing need for home care.	

			e. Theclient's medical nursing, rehabilitative, social and discharge planning needs. f. Areview of all medications the client is currently using in order to identifyany potential adverse effects and drug reactions, including ineffective drugtherapy, significant side effects, significant drug interactions, duplicatedrug therapy, and noncompliance with drug therapy. g. Theclient's primary caregiver(s), if any, and other available supports, includingtheir willingness and ability to provide care, and their availability andschedules. h. Theclient's representative, if any. i. Incorporationof the current version of the Outcome and Assessment Information Set (OASIS)items, as specified by the Secretary. The OASIS data items determined by theSecretary must include: clinical record items, demographics and client history,living arrangements, supportive assistance, sensory status, integumentarystatus,	

			status, neuro/emotional/behavioralstatus, activities of daily living, medications, equipment management, emergentcare, and data items collected at inpatient facility admission or dischargeonly. 3. The assessment will identify theclient's primary caregiver(s), if any, and other available supports, includingtheir willingness and ability to provide care, and availability and schedules.If there is an identified client representative, that will also be documented. 4. Nutritional status is assessed.Clients who are identified as being at moderate or high risk are referred tothe appropriate resource for follow-up and treatment as indicated. This mayinclude the physician, registered dietitian, or other qualified professional.High risk indicators may include: a. Weightloss of ten (10) pounds in thirty (30) days. b. Significantunderweight or overweight status.	

			c. Changein functional status. d. Inappropriatedietary habits. e. Nutritional-relateddisorders. **Assessment Strategies** · Interview · Interaction · Direct observation · Inspection · Clinical measurements · Clinical reasoning · MD or Facility information 5. Functional status is assessed anddocumented using the OASIS data elements with agency specific assessmentcriteria. When the client is not required to have OASIS data collected, thefunctional status of the client will be assessed using this tool or a relatedtool. 6. Assessment and documentation are maderegarding whether the home environment is suitable for providing home care.	

			7. Discharge planning is initiated, goalsare identified, and/or continuing care needs are recognized. 8. Assessments are prioritized based onclient need. All clients will have the Comprehensive Client Assessment completedwithin five (5) days of the initial visit. 9. Assessments will be completed byregistered nurses, physical therapists, or speech therapists. 10. Client populations with specializedneeds, i.e., mental health, pediatric, intrapartum, and hospice will be assessedby professionals with appropriate skills and in accordance with specificpolicies developed for those services. 11. Client needs are assessed, and careguidelines established based on the assessment data.	

			12. OASIS data collection is not requiredfor clients less than eighteen (18) years of age, prenatal/post-partum clients,or clients who receive only personal care or homemaker services. 13. Reassessments are conducted based onclient needs, physician/allowed non-physician practitioner (NPP) orders,professional judgment and/or OASIS or other regulatory requirement, and for anychanges in the plan of care will be sent to the physician/allowed non-physicianpractitioner (NPP). this policy will be monitored by the alternate Administrator; policy will be on-going.	
G1028	Protection of records 484.110(d) Standard: Protection of records. The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164. Based on observation, record review and interview, the home health agency failed to ensure all patients clinical records were	G1028	Clinical Record Confidentiality: Policy; All client information shall be treated as confidential andwill be available only to authorized users. PUPOSE:	2022-08-19

	safeguarded against loss or unauthorized use. Findings include: An undated agency policy titled Patient s Bill of Rights stated, ... The patient has the right to confidentiality of clinical records maintained by the ... agency .... During an interview on 6/06/2022 at 11:02 AM, when queried how the agency maintained clinical records, the administrator and alternate administrator both indicated there were no paper charts or clinical documents, and everything was located in the electronic medical record (EMR).		To assure that confidentiality of data and information ispreserved. To assure security measures are in place to safeguard theintegrity of information in clinical and billing records. SPECIAL INSTRUCTIONS Authorized users will be identified as: The client , his/her representative and the client'sphysician. Staff members and contract staff providing and supervisingclient care. Administrator , Director of clinical services, and caseManagers. Authorized state or federal health authorities, accreditingbodies, or other authorized by state and federal statues. All requests forclinical records will be submitted to the Administrator or Director of clinicalservices or designee	

	During an interview on 6/06/2022 at 1:57 PM, when queried where the current plan of care with the physician s signature (for patient #1) was located in the EMR, the administrator and alternate administrator both indicated it was a paper copy, and not in the EMR. When queried on the location of the paper copy, the administrator indicated she thought she could find it. When queried if the paper copy was located on the premises, the administrator indicated she d look, and walked to the back of the office. During this time, the alternate administrator indicated if the document was not on the premises, he could get it. When queried where the document would be if not on the premises, the alternate administrator stated, We have them [clinical documents] at home as well. During this time, the surveyor and alternate administrator walked to the back of the office. Two large (30 gallon) black plastic garbage bags and 1 white (13 gallon) garbage bag was observed on a table and the floor in an open area. The bags contained hundreds of clinical and billing documents for the agency s patients, which were not in separate, patient specific records. Additional records were observed on an open bookshelf. Unsecured documents located included those for patients #1, 2, 3, 4, 5, 6, and 7. During an interview on 6/13/2022 at 4:00 PM, the surveyor requested a copy of patient #7 s 2021 discharge summary, and admission order for the 5/22/2022 re-admission, as they were not included in the EMR. The alternate administrator indicated he had them, they were on a disk at home, and he wished he brought it. 17-15-1(c)		Written consent of the client or representative is required All individual who collect, handle, or disseminateinformation will be informed of their responsibilities to protect data Clinical records will be stored in a locked cabinet or room.When in use, the record will be kept in a secure area and not left unattendedin areas accessible to unauthorized ndividuals. Categories of personnel who may review clinical recordsinclude: Nursing staff Paraprofessionals providing care Therapy practitioners and social workers Administrative and management Member of accreditation and/or survey teams	

			Healthmasters will store all client files in locked cabinets/ locked office only Alternate administrator will monitor this policy; on-going	
N9999	Final Observations Based on record review and interview, the home health agency failed to ensure at least 50% of non-licensed employees (home health aides [HHAs]) were randomly drug tested annually, for all HHAs employed by the agency (HHA 1, 2, 3). Findings include: An undated agency policy titled "Drug Testing" stated, "... The agency must, on an annual basis, randomly test at least fifty (50) percent of the agency's employees who meet both of the following ... Provides direct patient care ... Not licensed by a board ...." Employee record review for HHA 1 (date of hire 8/25/2011) was completed on 6/9/2022, which failed to indicate any drug tests were administered. Employee record review for HHA 2 (date of	N9999	Healthmasters drug policy: Human Resource Drug Testing All Staff PURPOSE: To provide a controlled substance, drug and alcohol freeworkplace for the safety of all employees (leased, hired, or otherwise) andcustomers. In order to further this objective the following rules governing alcoholand illegal drugs and inhalants in the workplace have been established. Policy: Prior to hire all employees must sign a consent agreeing tosubmit to a drug screening which shall at minimum be a	2022-08-31

	hire 3/13/2017) was completed on 6/9/2022, which failed to indicate any drug tests were administered. Employee record review for HHA 3 (date of hire 7/31/2009) was completed on 6/9/2022, which failed to indicate any drug tests were administered. On 6/06/2022 at 11:55 AM, verification of compliance with Indiana drug screening requirements was requested to the administrator, alternate administrator, and person 3 (human resource manager). On 06/09/2022 at 12:20 PM, a second request for verification of compliance with Indiana drug screening requirements was requested to the administrator, alternate administrator, and person 3. On 6/09/2022 at 2:00 PM, the administrator indicated he wasn't sure if drug screens were done. Upon survey exit, no further information was provided.		five(5) panel test thatincludes testing for amphetamines, cocaine, marijuana, opiates and PCP. Whileon Healthmasters ,Inc. premises and while conducting business atHealthmasters,Inc. patient site, no employee may use, possess distribute, orsell illegal drugs. The legal use of prescribed drugs is permitted on the jobonly if does not impair an employee's ability to preform essential function ofthe job in an effective and safe manner. Alcohol will not be permitted or consumedin the agency office, premises, or patient's location. The illegal manufacture, distribution, dispensing,possession, sales, purchase, receipt or transmittal of controlled substance, oran attempt to any of the foregoing, while Healthmasters,Inc. or client company'sproperty or on company related business is prohibited. ** TESTING B) The agency must, on a annual basis, randomlytest at least fifty(50) percent of the agency'semployees who meet both of the following:	

			Provide direct patient care or has direct contact with apatient; and is not licensed by a board or a commission under Ind. Code 25 (Ind. Code 16-27-2.5-2(b)(1). When Healthmasters has reasonable suspicion that an employee is engaged in the illegal use of a controlled sustance, the agency shall either discharge or discipline with a minimum of a six(6) month suspension of any employee who refuses to submit to a drug test. Healthmasters has three employees who meet these requirements,we will test two(2) of the three no later than 08-31-22. Alternate Administrator will monitor this policy ; on-going	

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