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	09/14/2022

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 a re-licensure survey of a home health agency. The survey visit took place from 9/7/2022 to 9/14/2022 . Facility ID: IN006389 Census: 7	N0000		2022-10-24
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure Survey of a Home Health provider. Survey Dates: 9/7/2022 to 9/14/2022 Census: 7 During this survey, 6 condition level citations	G0000		2022-10-24

	remain. During this survey, 7 standard level citations were corrected, 3 standard level deficiencies remained, and one new standard deficiency was cited. 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 §484.60: Care Planning, Coordination of Services, and Quality of Care 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 evaluation programs for a period of two years beginning 6/13/2022 and continuing through 6/12/2024. Quality Review Completed 09/30/2022			
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: 9/7/2022 to 9/14/2022	E0000		2022-10-24

	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.			
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, §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	E0001	Healthmasters has completed anEmergency Preparedness plan, which will be reviewed and updated at least every two(2) years. The plan is based on risk (HVA) assessments' plan includes COVID-19pandemic. Our plan also includes contingency plans for provision of uninterruptedcare for patients with suspected/confirmed COVID-19. Our plan has anemergency preparedness communication plan which includes the use of otheremergency staffing in the event of an emergency to ensure the healthcare needsof the patients are met. Our plan has namesand contact information for other entities providing services underarrangement. We have developed acommunications plan which includes primary and alternate means for communicatingwith our staff. Our emergency preparedness plan will include training andtesting programs	2022-10-06

	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 least every 2 years (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); included contingency plans for provision of uninterrupted care for patients with suspected/confirmed COVID-19 (see tag E0017); 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		(once up and running). Alternate Administrator will monitor; on-going	

	(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.			
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). 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	E0004	E0004: 10/06/2022 Safety Manager, on-going Our new emergency preparedness plan will be reviewed/ or updatedat least annually. As required by new policy: Emergency Preparedness ManagementPolicy.	2022-10-06

	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. Findings include:		Safety Manager will monitor; on-going	

	An undated agency policy received on 9/13/2022, 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. Review of the agency's Emergency Preparedness binder on 9/13/2022 failed to evidence any documentation since 2019. During an interview on 9/13/2022 at 10:24 AM, the alternate administrator indicated he planned to update the agency's emergency preparedness plan since the last survey, but had not yet.			
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), §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)	E0006	We have developed an emergency preparedness plan whichincludes the following: Our emergency preparedness plan includes a facility-basedand community based risk assessment(HVA). We have strategies for addressingemergency events include in our HVA.	2022-10-05

	[(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, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.		Safety Manager will monitor: on-going	

	*[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 agency's emergency preparedness program included a facility-based and community-based risk assessment, and Included strategies for addressing emergency events identified by the risk assessment. The findings include: An undated agency policy received on 9/13/2022, 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.			

	Review of the agency's Emergency Preparedness binder failed to evidence a current facility-based and community based risk assessment. During an interview on 9/13/2022 at 10:28 AM, the alternate administrator stated, "I need to do a risk assessment plan yet", and offered no further documentation.			
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)	E0013	Healthmastershas completed an Emergency Preparedness plan, which will be reviewed and updatedat least every two (2) years. The plan is based on risk (HVA) assessments' planincludes COVID-19 pandemic. Our plan also includes contingency plans forprovision of uninterrupted care for patients with suspected/confirmed COVID-19. Our plan has an emergency preparedness communication planwhich includes the use of other emergency staffing in the event of an emergencyto ensure the healthcare needs of the patients are met. Our plan has names and contact information for otherentities	2022-10-06

	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 section. The policies and procedures must 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 updates at least every 2 years. The findings include: An undated agency policy received on		providing services under arrangement. We have developed a communications plan which includesprimary and alternate means for communicating with our staff. Alternate Administrator will monitor: on-going.	

	9/12/2022, titled "Disaster/Emergency Preparedness", indicated the agency shall document emergency events and revise the emergency plan as needed. Review of the agency's Emergency Preparedness binder failed to evidence policies and procedures reviewed or updated since 2019. During an interview on 9/13/2022 at 10:24 AM, the alternate administrator indicated he planned to create current emergency preparedness policies and procedures since the last survey, but had not yet.			
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	E0017	OurEmergency Preparedness policies and procedures now include contingency plansfor uninterrupted care for patients with suspected or confirmed COVID-19. We willfollow our pandemic policy for COVID-19, policy to prevent spread Alternate Administrator will monitor; on-going	2022-10-06

	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. The findings include: An undated agency policy received on 9/12/2022, titled "Disaster/Emergency Preparedness", failed to include contingency plans for patients with suspected or confirmed COVID-19. 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 9/13/2022 at 11:41 AM, the alternate administrator indicated the agency did not have a policy with a contingency plan for providing care of patients with suspected or confirmed COVID-19.			
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).	E0024	Our new emergency preparedness plan will include use ofother emergency staffing in the event of an emergency, to ensure the healthcareneeds of the patients are met. Lists of emergency staffing can be found insections of emergency	2022-10-06

	[(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. *[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. The findings include: An undated agency policy received on 9/12/2022 titled, "Disaster/Emergency Preparedness", failed to include the procedure		plan. Safety Manager will monitor; on-going	

	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. An undated agency policy received on 9/13/2022, titled "Communication Plan for Emergency Preparedness", failed to evidence any specific agency and staff information. The subsection of the policy titled, "Practice / Procedure / Implementation" evidenced blank lines where agency specific information was not entered. During an interview on 9/13/2022 at 3:26 PM, the alternate administrator indicated he needed to fill out the agency specific information in the policy and he did not have an additional documented communication plan. The alternate administrator indicated he had volunteers who would help in an emergency, but did not have a documented plan or policy for the use of volunteers in the event of an emergency.			
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:]	E0030	Our new emergency preparedness plan will include use ofother emergency staffing in the event of an emergency, to ensure the healthcareneeds of the patients are met. Lists of emergency staffing can be found insections of emergency plan. Alternate Administrator will monitor: on-going	2022-10-07

(1) Names and contact information for the following:

(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. (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.

(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.

The findings include:

An undated agency policy received on 9/12/2022, 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.

An undated agency policy received on 9/13/2022, titled "Communication Plan for Emergency Preparedness", failed to evidence any names or contact information for patients' physicians or volunteers. The subsection of the policy titled, "Practice / Procedure / Implementation" evidenced blank lines where agency specific information was not entered.

Review of the agency's Emergency Preparedness binder failed to evidence an updated communication plan which included names and contact information for patients' physicians and volunteers.

During an interview on 9/13/2022 at 3:26 PM, the alternate administrator indicated the agency's emergency preparedness failed to include names and contact information for patients' physicians and volunteers.

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), §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. The findings include: An undated agency policy received on 9/13/2022, titled "Communication Plan for Emergency Preparedness", had a subsection	E0032	Our emergency preparedness plan will include an alternativecommunications plan to communicate with staff: Our alternative communications, utilize Tiger Connect Corporation: Tiger Connect, will use phone communications in emergencysituations. Tiger text , will provide instant texting to staff inemergency situation Alternate Administrator will monitor; on-going	2022-10-07

	titled "Practice / Procedure / Implementation", which indicated the agency would maintain a staff notification tree. The notification tree would include staff members' home address and an alternate means of communication. Review of the agency's Emergency Preparedness binder failed to evidence a current staff notification tree including an alternate means of communication. During an interview on 9/13/2022 at 3:26 PM, the alternate administrator indicated he had not yet created a current staff notification tree including an alternate means of communication.			
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	E0036	Healthmasters has completed a table top training, based on an event from our HVA riskassessment. The training was fully documented, staff sign in sheets provided. Thetraining was conducted by our Safety Manager. Safety Manager will monitor; on- going	2022-10-01

	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 section. The training and testing program 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.			

	The findings include: An undated agency policy received on 9/12/2022, titled "Disaster/Emergency Preparedness", indicated the agency shall review the emergency plan annually, testing would occur annually. Review of the agency's Emergency Preparedness binder failed to evidence review or testing of the plan since 2019. During an interview on 9/13/2022 at 10:24 AM, the alternate administrator indicated the agency failed to update the emergency preparedness training and testing program since 2019.			
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.	E0037	Healthmasters has completed a table top training, based on an event from our HVA riskassessment. The training was fully documented, staff sign in sheets provided. Thetraining was conducted by our Safety Manager. Training will be provided everytwo(2) years, and be completely documented. Safety Manager will monitor on-going	2022-10-01

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

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.

Based on record review and interview, the agency failed to ensure emergency preparedness training was provided and documented at least every 2 years.

The findings include:

An undated agency policy received on 9/12/2022 titled "Disaster/Emergency Preparedness" indicated agency employees would be oriented on the emergency plan during the new hire process and annually thereafter.

Review of the agency's Emergency Preparedness binder on 9/12/2022 failed to evidence employee emergency preparedness education.

During an interview on 9/13/2022 at 10:28 AM, the alternate administrator indicated emergency preparedness training should be documented and maintained in the Emergency Preparedness binder. The alternate administrator indicated the agency failed to document staff emergency preparedness

	training since 2019. When queried, the alternate administrator stated, "We used to do that. We need to get back to doing that..."			
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 has completed a table top training, based on an event from our HVA riskassessment. The training was fully documented, staff sign in sheets provided. Thetraining was conducted by our Safety Manager. Training will be provided everytwo(2) years, and be completely documented. Safety Manager will monitor ; on-going	2022-10-01

	(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			

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

	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 conduct exercises to test the emergency plan annually.			

	The findings include: An undated agency policy received on 9/12/2022, 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. Review of the agency's Emergency Preparedness binder failed to evidence full scale or table-top exercise since 2019. During an interview on 9/13/2022 at 10:28 AM, the alternate administrator indicated the agency had not executed the emergency preparedness plan or participated in a full scale or table-top exercise since 2019.			
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 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 record review and interview, the agency failed to: ensure a registered nurse conducted a comprehensive assessment within 48 hours of the start of care or patient's return home in 1 of 1 records reviewed receiving LPN (licensed professional nurse) services (see tag G0514); ensure a comprehensive assessment was completed no later than 5 calendar days after the start of care (see tag G0520); ensure the patient's medication list was current,	G0510	After review of the start of care assessment process for ourclient returning from out of the country and discharged after being out of ourservices on 06/20/2022, Client was referred to agency on 08/22/2022, by their physician.We held the referral until 08/30/2022, waiting for documentation from thecaregiver. This documentation was found to be prior-authorization informationand should not have delayed the start of care process. All future start of cares will	2022-10-05

	reviewed at least every 60 days, included the route, the dose, and/or the indications for use of all medications used; and/or failed to ensure a drug regimen review was completed to identify duplicate drug therapy in 4 of 6 records reviewed (see tag G0536); ensure the registered nurse (RN) completed comprehensive re-assessments within the last 5 days of every 60 days beginning with the start-of-care date in 2 of 5 records reviewed receiving only home health aide services (see tag G0546). 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.		(ClientAdmission Process), No exception. Administrator will monitor, 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 homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the agency failed to ensure a registered nurse conducted a comprehensive assessment within 48 hours of	G0514	. We have reviewed 100% of all active clinical records forthis deficient practice. We found the problem one (1) was our failure tocomplete a recertification(follow-up) reassessment for period:06/04/2022-06/08/2022. Seven (7) Skill nursing visits were completed between06/08/2022 – 06/17/2022. Patient was discharged 06/20/2022, after services werestop, because	2022-10-21

	the start of care or patient's return home in 1 of 1 records reviewed receiving LPN (licensed professional nurse) services (#3). The findings include: An undated policy received on 9/13/2022, titled "Comprehensive Client Assessment" stated, " ... The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the client's return home, or on the physician ordered start of care date ... Assessments will be completed by registered nurses, physical therapists, or speech therapists...." Clinical record review on 9/9/2022 evidenced patient #3 was receiving skilled nursing care 10 hours per day, 5 days per week. Review of the nurse's visit notes failed to evidence any visits were made from 6/17/2022 to 8/30/2022. Clinical record review failed to evidence any comprehensive assessments made by a registered nurse from 6/17/2022 to 9/8/2022.		patient was out of our services area. Patient return to ourservice area and was referred to our agency for service 08/22/2022 by theirphysician. We held the start of care until 08/30/2022. We were waiting fordocumentation from caregiver. Problem two (2) we fell advise patient physician we wereunable to start services until 08/30/2022 and request a referral for that date.This would have allowed us to be in accordance with our policy (ClientAdmission Process), completing assessment within 48hours. We cannot go back, and change completed assessments,however, we have put into place monthly meeting requirements, to include theAdministrator and each skilled nurse for case reviews. This will assureassessment are completed in accordance with our policy (comprehensive clientassessment). The monthly meeting will prevent any missed, or late assessments,these meetings will be on-going.	

	During an interview on 9/14/2022 at 10:36 AM, the administrator indicated no visits were made from 6/17/2022 to 8/30/2022 because patient #3 was out of the country with their family. The administrator indicated LPN (licensed professional nurse) 1 resumed the patient's care on 8/30/2022. When queried, the administrator indicated a registered nurse should have performed a start of care visit including a comprehensive assessment on 8/30/2022. 410 IAC 17-14-1(a)(1)(A)		The Administrator will be responsible for all monthly meetings	
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 record review and interview, the agency failed to ensure a comprehensive assessment was completed no later than 5 calendar days after	G0520	. We have reviewed 100% of all active clinical records forthis deficient practice. We found the problem one (1) was our failure tocomplete a recertification(follow-up) reassessment for period:06/04/2022-06/08/2022. Seven (7) Skill nursing visits were completed between06/08/2022 – 06/17/2022. Patient was discharged 06/20/2022, after	2022-10-24

	the start of care in 1 of 1 records reviewed receiving LPN (licensed professional nurse) services (#3). The findings include: An undated policy received on 9/13/2022, titled "Comprehensive Client Assessment" stated, " ... The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the client's return home, or on the physician ordered start of care date ... Assessments will be completed by registered nurses, physical therapists, or speech therapists...." Clinical record review on 9/9/2022, for patient #3, evidenced a plan of care for the certification period 8/30/2022 to 10/28/2022. Clinical record review failed to evidence any comprehensive assessment from 8/25/2022 to 9/8/2022. During an interview on 9/14/2022 at 10:36 AM, the administrator indicated no visits were made from 6/17/2022 to 8/30/2022 because patient #3 was out of the country with their family. The administrator		services werestop, because patient was out of our services area. Patient return to ourservice area and was referred to our agency for service 08/22/2022 by theirphysician. We held the start of care until 08/30/2022. We were waiting fordocumentation from caregiver. Problem two (2) we fell advise patient physician we wereunable to start services until 08/30/2022 and request a referral for that date.This would have allowed us to be in accordance with our policy (ClientAdmission Process), completing assessment within 48hours. We cannot go back, and change completed assessments,however, we have put into place monthly meeting requirements, to include theAdministrator and each skilled nurse for case reviews. This will assureassessment are completed in accordance with our policy (comprehensive clientassessment). The monthly meeting will prevent any missed, or late assessments,these meetings will	

	professional nurse) 1 resumed the patient's care on 8/30/2022. When queried, the administrator indicated the agency failed to ensure a comprehensive assessment was performed by a registered nurse at start of care or any time since.		be on-going. The Administrator will be responsible for all monthly meetings	
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 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 the route, the dose, and/or the indications for use of all medications used; and/or failed to ensure a drug regimen review was completed to identify duplicate drug therapy, for 4 of 6 clinical records reviewed (#1, 3, 4, 5). The findings include: 1. An undated agency policy received on 9/14/2022, titled "Medication Profile" stated, "... The medication Profile must include at least the following ... Current medications ... Dose ...	G0536	The Administrator has requested up to date medication listfor all patients from their physician. They have been reviewed and updated andwill be included in their up coming plans of care. Medication lists will behandled in accordance with our new and updated policy: Medication Profile. Patients #4 and # 5, have identified and retained a physicianwho we have contacted for discharge and start of care information. Once weobtain this information, we will complete their discharge/start of care tobring the two back into compliance.	2022-10-07

	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 9/14/2022, 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. Clinical record review for patient #1 on 9/8/2022 evidenced a document titled, "Medication Profile", for certification period 7/16/2022 to 9/13/2022, which indicated the route for the following medications was PEG Tube (a feeding tube): Hydrocodone - Acetaminophen (a pain medication), Melatonin (a sleep aid), Nexium (an acid reducing medication), Polyethylene		All future start of cares will follow our: new policy (ClientAdmission Process), No exception. Administrator will monitor; on-going	

	Glycol (a laxative), Polyvitamin /Iron, Q-Dryl (an antihistamine), and Reclipsen (a birth control medication). Review of the home health aide care plan for certification period 7/16/2022 to 9/13/2022 evidenced one of the aide's tasks was preparing the patient's meals. During an interview on 9/13/2022 at 11:52 AM, the administrator indicated patient #1 ate normally, by mouth, and did not use a feeding tube. When queried if the patient had a feeding tube in place currently, the administrator stated, "I'm not sure". During an interview on 9/13/2022 at 3:04 PM, person #1 (family member and primary caregiver to patient #1) indicated patient #1 did not have a feeding tube, and hadn't in "a while". On 9/13/2022 at 3:04 PM, when informed of the findings, the administrator indicated the medication list was not correct, and needed to be updated with the correct route. 4. Clinical record review on			

	9/9/2022 for patient #3 evidenced a document titled, "Medication Profile", for certification period 8/30/2022 to 10/28/2022, which stated, " ... Excedrin Migraine [acetaminophen, aspirin and caffeine] Oral Tablet 250-250-65 MG [milligram] ... Every 6 hours Tab(s) 1 ... Excedrin Migraine Oral Tablet 250-250-65 MG PRN [as needed] Tab(s) ... Multivitamin Oral Liquid Daily 3:00 PM 15 mL [milliliter] ... 1 time a Day ... Multivitamins / Minerals Adult Oral Liquid 15 mL Daily ... Tylenol PRN 1 Tab ... Tylenol (160 mg /mL Elix [elixir] Every 4 Hours PRN ... Tylenol Extra Strength Oral Solution 160 MG / 5 ML ml ...Tylenol Extra Strength Oral Solution 160 MG / 5 ML PRN ... Tylenol for Children + Adults Oral Suspension 160 MG / 5 ML Every 6 hours PRN One tsp...." During an interview on 9/14/2022 at 11:02 AM, the administrator indicated each medication order should include the name of the medication, dosage, route, frequency, and indication for use if ordered PRN. When queried, the administrator			

there were so many repeated and incomplete medication orders. The alternate administrator interjected, "That's what the doctor wants". When queried, the administrator indicated the agency created the plan of care and the doctor signs it.

5. Clinical record review on 9/12/2022 for patient #4 failed to evidence a comprehensive assessment since 11/20/2020. Review of the patient's electronic medical record (Alora) failed to evidence any RN (registered nurse) visits since 11/20/2020. Clinical record review failed to evidence the patient's medication list was reviewed at least every 60 days.

During an interview on 9/14/2022 at 12:09 PM, the alternate administrator indicated there was no documented comprehensive assessment since 11/20/2020. The alternate administrator indicated he planned to "restart everything" after the last survey, but was waiting for the patient to change physicians.

6. Clinical record review on 9/12/2022 for patient #5 failed to evidence a comprehensive assessment since 7/11/2020. Review of the patient's electronic medical record (Alora)

	failed to evidence any RN (registered nurse) visits since 7/11/2020. Clinical record review failed to evidence the patient's medication list was reviewed at least every 60 days. During an interview on 9/14/2022 at 12:09 PM, the alternate administrator indicated there was no documented comprehensive assessment since 7/11/2020. The alternate administrator indicated he planned to "restart everything" after the last survey, but was waiting for the patient to change physicians. 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-	G0546	We have reviewed 100% all active clinical records for thisdeficient practice. We will strictly follow our policy (comprehensive clientassessment): “The assessment identifies facilitating	2022-10-07

	(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 comprehensive re-assessments within the last 5 days of every 60 days beginning with the start-of-care date in 2 of 5 records reviewed receiving only home health aide services (#4, 5). The findings include: 1. An undated agency policy received on 9/14/2022, 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 policy received on 9/13/2022, titled "Comprehensive Client Assessment" stated, " ... A thorough, well-organized, comprehensive and accurate assessment, consistent with the client's immediate needs will be completed for all clients in a timely manner ... The depth and frequency of ongoing assessments ... will be done at least once in every sixy (60) day period ... Assessments will be completed by registered nurses, physical therapists, or speech therapists...." 3. Clinical record review on 9/12/2022 for patient #4 failed to evidence a comprehensive assessment since 11/20/2020. Review of the patient's electronic medical record (Alora) failed to evidence any RN (registered nurse) visits since 11/20/2020. Clinical record review		factors and possiblebarriers to client reaching his or her goals including presenting problem. Thedepth and frequency of ongoing assessment will depend on client needs, goals,and the care treatment and services provided, but will be done at least once inevery sixty (60) day period We assure that we complete the assessment within (5)DAYS, of every (60) day period. We have put ontoplace, monthly meeting requirements, to include the Administrator, and skillnursing staff persons, to review all start of care, and ensure a comprehensiveassessment is conducted within 5 days of every 60-day period, for all clients. The Administrator will monitor the procedure, on-going	

	was reviewed at least every 60 days. During an interview on 9/14/2022 at 12:09 PM, the alternate administrator indicated there was no documented comprehensive assessment since 11/20/2020. The alternate administrator indicated he planned to "restart everything" after the last survey, but was waiting for the patient to change physicians. 6. Clinical record review on 9/12/2022 for patient #5 failed to evidence a comprehensive assessment since 7/11/2020. Review of the patient's electronic medical record (Alora) failed to evidence any RN (registered nurse) visits since 7/11/2020. Clinical record review failed to evidence the patient's medication list was reviewed at least every 60 days. During an interview on 9/14/2022 at 12:09 PM, the alternate administrator indicated there was no documented comprehensive assessment since 7/11/2020. The alternate administrator indicated he planned to "restart everything" after the last survey, but was waiting for the patient to change physicians. 410 IAC 17-14-1(a)(1)(B)			
G0570	Care planning, coordination, quality of care	G0570	The Administrator has reviewed	2022-10-07

	484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interview, the 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 in 6 of 6 clinical records reviewed (see tag G0572); ensure each patient's plan of care included equipment required, frequency and duration of visits to be made, rehabilitation potential, nutritional requirements, education and training to facilitate a timely discharge, all		all plans of care to identityall elements required, utilizing our new policy (Plan of Care). All plans ofcares will be checked for all requirements of our new policy, to ensure thiswill not be a recurring issue. Administrator will monitor; on-going	

	treatments, safety measures to protect against injury, and patient's allergies in 4 of 4 patient records with a plan of care (see tag G0574). The 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 §484.60: Care Planning, Coordination of Services, and Quality of Care.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the 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 in 6 of 6 clinical records reviewed (#1, 2, 3, 4, 5, 6).	G0572	We will prevent this deficiency from recurring in the futureas follows: We will conduct monthly meetings with the Administrator and skillednurse staff, we will review comprehensive assessments to insure we are timelyin our 60-day requirement. These meeting will review all comprehensive assessments,and their content. We will review all plans of care for each assessment, toreview job requirements outlined in the plans of care for nurse and home healthaide (if applicable). We have reviewed 100% of active clinical records for	2022-10-24

	The findings include: 1. An undated policy received 9/14/2022, titled "Plan of Care", stated, " ... Home care services are furnished under the supervision and direction of the client's physician ... The plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary, but at least every sixty (60) days...." 2. An undated policy received on 9/14/2022, titled, "Skilled Professional Services", stated, " ... Skilled professional services include skilled nursing services ... must assume responsibility for, but not be restricted to the following: ... Providing services that are ordered by the physician ... in the plan of care...." 3. Clinical record review for patient #1 on 9/8/2022 evidenced a plan of care for certification period 7/16/2022 to 9/13/2022, which stated, "Skilled Nursing Orders ... Order: Instructions / Teaching Emergency Information and Preparedness Planning...." Review of the patient's electronic medical record (Alora) for the certification period 7/16/2022 to 9/13/2022 failed to evidence the nurse taught the patient or caregiver about emergency preparedness. During an interview on 9/13/2022 at 12:30 PM, the administrator indicated ordered skilled nurse teaching should be performed at each skilled nurse visit and documented in the patient's record. When informed of the findings, the administrator was silent and offered no further documentation. 4. Clinical record review for patient #2 on 9/9/2022 evidenced a plan of care for certification period 7/17/2022 to 9/14/2022, which failed to include a physician's signature.		thisdeficient practice. We gave special attention to orders for skill nursing.These will be monitored along side the plans of care. The Administrator will be responsible for monitoring thesemeeting, meetings will be on-going.	

During an interview on 9/13/2022 at 3:12 PM, the administrator indicated the the agency did not have a plan of care signed by the physician for the current certification period.

5. Clinical record review for patient #3 on 9/9/2022 evidenced a plan of care for certification period 8/30/2022 to 10/28/2022, which failed to include a physician's signature.

During an interview on 9/14/2022 at 10:51 AM, the alternate administrator indicated the agency did not have a plan of care signed by the physician for the current certification period.

6. Clinical record review for patient #4 on 9/12/2022 failed to evidence a current plan of care.

During an interview on 9/14/2022 at 12:09 PM, the alternate administrator indicated the agency did not have a current plan of care for patient #4. The alternate administrator indicated he planned to "restart everything" after the last survey, but was waiting for the patient to change physicians.

7. Clinical record review on

	to evidence a current plan of care. During an interview on 9/14/2022 at 12:09 PM, the alternate administrator indicated the agency did not have a current plan of care for patient #5. The alternate administrator indicated he planned to "restart everything" after the last survey, but was waiting for the patient to change physicians. 8. Clinical record review for patient #6 on 9/13/2022 evidenced a plan of care for certification period 8/26/2022 to 10/24/2022, which indicated the nurse was to perform the following duties: Teach medication safety, teach orthopedic safety, teach emergency preparedness planning, teach ambulation safety, teach hazardous material safe disposal, observe and assess compliance with pain medications, teach pain control measures, teach side effects of pain medication, teach activity restrictions rationale. Review of the patient's electronic clinical			

	record (Alora) failed to evidence the nurse completed any of these tasks. During an interview on 9/14/2022 at 12:39 PM, the administrator indicated the nurse only did recertification and supervisory visits for patient #6. When queried about the skilled nurse duties ordered in the plan of care, the administrator stated, "I don't know how those got on there". 410 IAC 17-3-1(a)			
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;	G0574	The Administrator has checked all the agency recent plan ofcare. We have found that our patient physicians have been slow in providing theirsignatures, we have communicated with each of the offices and arranged toimprove the time frame. We also will make a better effort to complete allsections of our plans of care, completely. We will utilize our new policy;(Plan of Care) to ensure that we complete all sections of our	2022-10-06

	(vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the agency failed to ensure each patient's plan of care included equipment required, frequency and duration of visits to be made, rehabilitation potential, nutritional requirements, education and training to facilitate a timely discharge, all treatments, safety measures to protect against injury, and patient's allergies in 4 of 4 patient records with a plan of care (#1, 2, 3, 6). The findings include: 1. An undated agency policy received on 9/14/2022, titled, "Plan of Care", stated " ... An individualized Plan of Care signed by a physician ... shall be required for each client		plans of care. Administrator will monitor : on-going	

	personal care services ... the Plan of Care shall be completed to include: ... Type, frequency, and duration of all visits / services ... Need for / presence of home medical equipment and assistive devices .... Prognosis ... Rehabilitation potential ... Functional limitations and precautions ... Activities permitted or restrictions ... Specific dietary or nutritional requirements or restrictions ... Medications, treatments, and procedures ... Medical supplies and equipment required ... Any safety measures to protect against injury ... Treatment goals ... Instructions for timely discharge or referral ... discharge plans .... All of the above must always be addressed on the Plan of Care...."			

	2. Clinical record review for patient #1 on 9/8/2022 evidenced a plan of care for certification period 7/16/2022 to 9/13/2022. The plan of care had a subsection titled, "Nutritional Requirements", which was blank. The plan of care had a subsection titled "Discharge Plan(s)", which stated, "no discharge plan". During an interview on 9/13/2022 at 11:52 AM, the administrator indicated she thought the patient "ate normal", but wasn't sure, but that information should have been included on the plan of care. When queried, the administrator indicated there was no discharge plan because they were a long-term patient they didn't plan to discharge. 3. Clinical record review for patient #2 on 9/9/2022 evidenced a plan of care for certification period 7/17/2022 to 9/14/2022, which indicated the patient was taking Warfarin (a blood thinner medication). Review of the plan of care failed to evidence Bleeding Precautions. The following subsections of the plan of care			

	Needs, and Homebound Status. The subsection titled, "Discharge Plan(s)" stated, "no discharge plan". During an interview on 9/13/2022 at 2:11 PM, the administrator indicated all subsections of the plan of care should be completed. When queried, the administrator indicated patient #2 was taking Warfarin, and Bleeding Precautions should be included on the Plan of Care. 4. Clinical record review for patient #3 on 9/9/2022 evidenced a plan of care for certification period 8/30/2022 to 10/28/2022, which indicated the patient had a G-tube (feeding tube inserted through the abdomen into the stomach). Review of the plan of care failed to evidence G-tube site care, assessment, instructions for use, equipment required, and aspiration precautions. The following subsections of the plan of care were blank: Nutritional Requirements, Rehabilitation Potential, Discharge Plan, and Caregiver Needs. The plan of care indicated the patient was on Anticoagulant (blood thinner)			

	Precautions and required teaching about oxygen use safety. Review of the plan of care failed to evidence the patient was taking any blood thinners or the patient was on oxygen. Review of the plan of care indicated the patient had seizures, but failed to evidence seizure precautions. During an interview on 9/14/2022 at 11:39 AM, the administrator indicated patient #3 should be on aspiration and seizure precautions. The administrator indicated patient #3 was not on blood thinners or oxygen, and those were put on the plan of care in error. When queried, the administrator indicated she thought the patient might be taking a soft diet by mouth, but probably still had the G-tube, but she wasn't sure. The administrator then indicated they probably just clean the G-tube area when the patient gets a bath, but not sure what it was cleaned with. When queried, the administrator indicated the plan of care failed to clearly evidence G-tube instruction for observation, use, and site care. 5. Clinical record review for			

	patient #6 on 9/13/2022 evidenced a plan of care for certification period 8/26/2022 to 10/24/2022 which failed to evidence nutritional requirements and discharge plans. The plan of care had a subsection titled, "Home Health Aide Orders" which stated, " ... Home Health Aide 3wk9 [three times a week for 9 weeks] 1-24 hrs per day ...." The plan of care failed to evidence a set number of hours for home health aide visits. During an interview on 9/14/2022 at 12:23 PM, the administrator indicated nutritional requirements and discharge plans should be included in the plan of care. The administrator indicated the agency provided home health aide services 6 hours per day, 7 days a week. When queried why the frequency of visits did not match what was written in the plan of care, the administrator shuffled papers on a desk and was silent. 410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(D)(ii, iii, v, vi, viii, ix, x, xi)			

G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview, the agency failed to have at least one performance improvement project either in development, on-going or completed. The findings include: An undated agency policy received on 9/13/2022, titled "Quality Assessment & Performance Improvement Plan" indicated the agency would establish and maintain an	G0658	Healthmasters has one performance improvement project indevelopment/on going. We have based our performance improvement, maintaining azero hospitalization of our patients. We believe if we can reduce/eliminate hospital stays, we canmaintain healthy patients . This is the topic of our QAPI meeting/training. Administrator will monitor: on-going	2022-10-08

	Performance Improvement (QAPI) program. Record review evidenced an agency document titled, "QAPI MEETING", dated 8/20/2022, which stated, " ... The governing body is responsible for ensuring the following: a. That an ongoing program for quality improvement annd patient safety is defined, implemented and maintained b. Healthmasters, Inc quality and assessment performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness...." During an interview on 9/13/2022 at 11:41 AM, the alternate administrator indicated the QAPI meeting minutes was the only new QAPI documentation since the last survey. When queried, the alternate administrator indicated the agency had not yet developed a performance improvement project.			
G0686	Infection control education 484.70(c)	G0686	All staff have received training on COVID-19 prevention; viaour pandemic policy for COVID-19	2022-09-17

	Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). Based on record review and interview, the agency failed to ensure all staff were competent in and adhered to infection prevention requirements regarding COVID-19. The findings include: An undated agency policy received on 9/13/2022, 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 ...." Personnel record review on 9/9/2022 failed to evidence any education or training on infection prevention and COVID 19 for Registered Nurse 1, Licensed Practical Nurses 1 and 2, and Home Health Aides 1, 2 and 3.		(policy section). Staff has received trainingon Supplies and personal protective equipment: · A) Surgical masks · B) N95 face mask/respirator(as needed) · C) Gloves · D) Goggles and Disposable Gowns as needed whendealing with clients who have the illness · E) Antimicrobial soaps and alcohol-based handhygiene products · F) Other disposables · G) Cloth masks may also be used and should belaundered after each use · H) follow your personal protective equipment orUniversal precautions policy for details Administrator will monitor; on going	

	During an interview on 9/13/2022 at 11:45 AM, when queried, the administrator indicated she did not have any documentation staff was educated on infection control and COVID-19.			
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 agency failed to ensure the nurse prepared written patient care instructions for the home health aide in 3 of 5 records reviewed receiving home health aide (HHA) services (#4, 5, 6). The findings include: 1. An undated policy received 9/13/2022, titled, "Home Health Aide Care Plan", stated, " ... A complete and appropriate Care	G0798	We will prevent this deficiency from recurring in the futureas follows: We will conduct monthly meetings with the Administrator and skillednurse staff, we will review comprehensive assessments to insure we are timelyin our 60-day requirement. These meeting will review all comprehensive assessments,and their content. We will review all plans of care for each assessment, toreview job requirements outlined in the plans of care for nurse and home healthaide (if applicable). We have reviewed 100% of active clinical records for thisdeficient practice. We gave special attention to orders for skill nursing.These will be monitored along side the plans of care. The Administrator will be responsible for monitoring	2022-10-24

	performed by the Home Health Aide, shall be developed by a Registered Nurse or Therapist. All home health aide staff will follow the identified plan...." 2. Clinical record review for patient #4 on 9/12/2022 evidenced HHA services were provided three times a week from 7/4/2022 to 9/2/2022. Clinical record review failed to evidence an HHA care plan. 3. Clinical record review for patient #5 on 9/12/2022 evidenced HHA services were provided three times a week from 7/4/2022 to 9/2/2022. Clinical record review failed to evidence an HHA care plan. 4. Clinical record review for patient #6 on 9/13/2022 evidenced a plan of care for certification period 8/26/2022 to 10/24/2022, which stated, " ... Home Health Aide Orders ... Provide / Assist with Personal Care and assistance with ADL's [activities of daily living]...." Review of the plan of care failed to evidence specific patient care instructions for the HHA. Review of the patient's electronic medical record (Alora) failed to evidence a		thesemeeting, meetings will be on-going.	

	completed HHA Care Plan. 5. During an interview on 9/14/2022 at 12:23 PM, the administrator indicated the HHA Care Plan should be completed in Alora for each patient receiving HHA services. When queried, the administrator indicated she did not have a completed HHA Care Plan for patient #4, 5, or 6. 410 IAC 17-13-2(a)			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review and interview, the agency failed to ensure the home health aide (HHA) provided services included in the plan of care in 2 of 5 records reviewed receiving only home health aide services (#2, 6).	G0800	Our system to ensure this deficient practice will not recuris as follows: The home health aides will be monitored by the Allorasystem, all aides are required to complete their notes during their visit, wewill review Allora for all three aides daily to monitor the visits. We will evaluatethe visit based on the care plan instructions for the home health aide. Withdaily monitoring in Allora the deficient practice will not recur. The alternate Administrator will monitor this procedure,procedure will be	2022-10-24

	The findings include: 1. An undated policy received 9/14/2022 titled, "Home Health Aide: Documentation" stated, " ... Home Health Aides will document care / services provided on the home health aide charting form ... The original documentation shall be filed in the clinical record...." Clinical record review for patient #6 on 9/13/2022 evidenced a plan of care for certification period 8/26/2022 to 10/24/2022, which stated, " ... Home Health Aide Orders ... Provide / Assist with Personal Care and assistance with ADL's [activities of daily living]...." Review of the plan of care failed to evidence specific patient care instructions for the HHA. Review of the patient's electronic medical record (Alora) failed to evidence any HHA visit notes for certification period 8/26/2022 to 10/24/2022. Clinical record review evidenced an agency document titled, "CareConnect Visit Report"		on-going	

	administrator on 9/14/2022. The report evidenced a list of visit dates and times made by HHA 1 for patient #6, from 9/1/2022 to 9/9/2022. The report failed to evidence tasks performed at each visit. During an interview on 9/14/2022 at 12:23 PM, the administrator indicated the HHA should document what tasks are completed in Alora at the end of each visit. When informed of the findings, the administrator was silent. During an interview on 9/14/2022 at 1:30 PM, the alternate administrator indicated he wasn't sure why HHA 1's documentation did not include what was done at each visit, but he was going to contact Alora to try to figure it out. 2. Clinical record review on 9/9/2022 for patient #2 evidenced an HHA Care Plan which indicated the HHA was to check the patient's blood pressure at each visit.			

	Review of the HHA notes from daily visits from 7/17/2022 to 9/7/2022 failed to evidence any patient blood pressures. During an interview on 9/13/2022 at 12:34 PM, when queried, the administrator indicated the HHA should document the patient's blood pressure from each visit in the visit note.			
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 agency failed to ensure the registered nurse made an on-site supervisory visit at least every 60 days in order to observe and assess the aide while they were performing care in 2 of 5 patient records reviewed receiving only home health aide services (#4, 5).	G0814	We reviewed 100% of all active clinical records with homehealth aide non- skill cases provided by our agency. Cases which require asupervisory visit every 60 days. We have put all our cases in our Allora system to supervisethe required supervisory visits required, every 60 days. Our Allora system willenable our timely monitoring all home health aide supervisory visits, this willensure that this deficient practice will not recur. Monitored by Alternate Administrator, on-going	2022-10-07

The findings include:

1. An undated agency policy received 9/14/2022, titled "Home Health Aide Supervision" stated, " ... When Home Health Aide services are being furnished to a client, who does not require the skilled service of a nurse or therapist, a Registered Nurse (RN) must make a supervisory visit to the client's residence at least once every sixty (60) days...."

2. Clinical record review on 9/12/2022 evidenced patient #4 was receiving HHA (home health aide) visits 3 days per week from 7/10/2022 to 9/10/2022. Review of the patient's electronic medical record (Alora) failed to evidence any HHA Supervisory visits made by the RN since 7/14/2019.

3. Clinical record review on 9/12/2022 evidenced patient #5 was receiving HHA (home health aide) visits 3 days per week from 7/10/2022 to 9/10/2022. Review of the patient's electronic medical record (Alora) failed to evidence

	made by the RN. 4. During an interview on 9/14/2022 at 12:15 PM, the alternate administrator indicated the RN should perform an on-site HHA supervisory visit at least every 60 days and document that visit in the patient's record. When queried, the alternate administrator indicated he would see if the administrator had supervisory visit notes for patients #4 and #5. By the end of the survey, no further documentation was received.			
N9999	Final Observations Deficiency corrected. No citation.	N9999	not applicable	2022-10-08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Edward Harmon	Alternate Administrator	11/4/2022 7:02:25 PM