STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157262	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHMASTERS INC	**3200 WILLOWCREEK ROAD SUITE B , PORTAGE, Indiana, 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
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR §484.102 for Home Health Providers and Suppliers. Survey Dates: 11/14/22-11/17/22 Census: 6 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 and Medicaid Participating Providers and Suppliers.	E0000		
E0001	Establishment of the Emergency Program (EP) CFR(s): 484.102 §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.)	E0001		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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E0001	Continued from page 1 *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This CONDITION is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to: include an individualized emergency plan in the comprehensive assessment (see tag E0017); 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 health needs of the patient were met (see tag E0024); maintain an emergency preparedness communication plan which included names and contact information for staff, patient's physician, volunteers or entities providing services under arrangement (see tag E0030); develop and maintain an emergency preparedness communication plan which included primary and alternate means for communicating with facility staff, Federal, State, Tribal, Regional and local emergency management (see tag E0032); ensure emergency preparedness training was provided and documented every 2 years (see tag E0037); and failed to conduct an annual test of the emergency plan or include a full scale exercise that is community-based every 2 years (see tag E0039). The cumulative effect of these system 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 out of compliance with condition of participation 42 CFR §484.102: Emergency Preparedness Requirements for Medicare Participating Providers	E0001		

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E0001	Continued from page 2 and Suppliers.	E0001		
E0017	HHA Comprehensive Assessment in Disaster CFR(s): 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. This STANDARD is NOT MET as evidenced by: Based on record review and interview the home health agency failed to include individualized emergency plans in the event of an emergency and include it in the comprehensive assessment in 2 of 2 clinical records reviewed without a current plan of care. (#5, #6) Findings include: 1. An undated agency policy received 11/17/2022, titled, “Emergency Disaster Plan Orientation and Training,” stated, “… individual plans for each client must be included as part of the comprehensive client assessment ….” 2. Clinical record review on 11/15/2022 for patient #5, start of care 02/23/2013, failed to evidence an individualized emergency plan. 3. Clinical record review on 11/15/2022 for patient #6, start of care 04/22/2013, failed to evidence an individualized emergency plan. 4. During an interview on 11/14/2022, at 11:40 AM, the alternate administrator indicated	E0017		

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E0017	Continued from page 3 individualized emergency plans should be completed based on patient assessment.	E0017		
E0024	Policies/Procedures-Volunteers and Staffing CFR(s): 484.102(b)(5) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to develop and maintain an emergency preparedness communication plan which	E0024		

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E0024	Continued from page 4 included the use of volunteers or other emergency staffing in the event of an emergency to ensure the health needs of the patients were met. The findings include: Record review evidenced an undated agency policy received 11/17/2022 titled, “Communication Plan for Emergency Preparedness” which stated, “… The communication plan must include … names and contact information for … staff … entities providing services under arrangement … volunteers … federal state, tribal, regional or local emergency preparedness staff … other sources of assistance ….” Subsection of the policy titled “Practice/Procedure/Implementation” evidenced blank lines where agency specific information was not entered. This policy failed to evidence specific agency emergency staff/volunteer information. Review of the emergency preparedness binder received on 11/14/2022, failed to evidence names or contact information for staff, patient’s physicians, volunteers, or entities providing services under arrangement. During an interview on 11/14/2022, at 11:05 AM, the alternate administrator indicated the staff/call emergency list was not completed yet. During an interview on 11/14/2022, at 11:40 AM, the alternate administrator indicated he was working on getting a contract for Shift Key (staffing agency for healthcare professionals) to provide health care workers during an emergency.	E0024		
E0030	Names and Contact Information CFR(s): 484.102(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	E0030		

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E0030	Continued from page 5 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 [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.	E0030		

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E0030	Continued from page 6 *[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	E0030		

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E0030	Continued from page 7 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). This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to maintain an emergency preparedness communication plan which included names and contact information for staff, patient's physician, volunteers, or entities providing services under arrangement. Findings include: Record review evidenced an undated agency policy received 11/17/2022, titled, "Communication Plan for Emergency Preparedness" which stated, "... The communication plan must include … names and contact information for … staff, entities providing services under arrangement, client's physicians and volunteers …." The subsection of the policy titled, "Practice/Procedure/Implementation" evidenced blank lines where agency specific information was not entered. Review of the emergency preparedness binder, received 11/14/2022, failed to evidence any names or contact information for staff, patient's physicians, volunteers or entities providing services under arrangement. During an interview on 11/14/2022, at 11:05 AM, the alternate administrator indicated the staff emergency list was not completed yet.	E0030		
E0032	Primary/Alternate Means for Communication CFR(s): 484.102(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),	E0032		

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E0032	Continued from page 8 §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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to develop and maintain an emergency preparedness communication plan that included primary and alternate means for communicating with facility staff, federal, state, tribal, regional and local emergency management. Findings include: Record review evidenced an undated agency policy received 11/17/2022 titled, “Communication Plan for Emergency Preparedness” which stated, “… The communication plan must include … primary and alternate means for communicating with the agency’s staff, federal, state, tribal, regional, and local emergency management agencies ….” Subsection of the policy titled, “Practice/Procedure/Implementation" evidenced blank lines where agency specific information was not entered. This policy failed to evidence alternate means for communication with staff, Federal, State, tribal, regional, and local emergency management agencies.	E0032		

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E0032	Continued from page 9 Review of the emergency preparedness binder on 11/14/2022 failed to evidence any primary or alternate means for communication with the agency's staff, Federal, State, tribal, regional and local emergency management agencies. During an interview on 11/14/2022, at 11:05 AM, the alternate administrator indicated he does not have a current staff notification tree or current alternate means of communication but was working on getting Tiger Connect (a secure text messaging app) for phone and fax.	E0032		
E0037	EP Training Program CFR(s): 484.102(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The	E0037		

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E0037	Continued from page 10 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.	E0037		

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E0037	Continued from page 11 *[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.	E0037		

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E0037	Continued from page 12 (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	E0037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157262	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2022

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E0037	Continued from page 13 knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure emergency preparedness training was provided and documented every 2 years. Findings include: Record review evidenced an undated agency policy received 11/17/2022 titled, “Emergency Disaster Plan Orientation and Training” which stated, "... emergency disaster preparedness training will be provided at least every two years. The agency will maintain documentation of all Emergency Disaster Preparedness Training provided ….” Review of the emergency preparedness binder, received 11/14/22, failed to evidence documentation of employee emergency preparedness training. During an interview on 11/15/22, at 10:10 AM, the alternate administrator indicated the emergency plan was reviewed with staff but there was no sign in sheet because the review was informal. The alternate administrator indicated he gave updates to the staff regarding area police and hospitals in 2 counties.	E0037		
E0039	EP Testing Requirements CFR(s): 484.102(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:	E0039		

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E0039	Continued from page 14 (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions 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	E0039		

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E0039	Continued from page 15 functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise 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	E0039		

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E0039	Continued from page 16 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,	E0039		

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E0039	Continued from page 17 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.	E0039		

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E0039	Continued from page 18 *[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	E0039		

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E0039	Continued from page 19 that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in	E0039		

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E0039	Continued from page 20 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.	E0039		

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E0039	Continued from page 21 *[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. This STANDARD is NOT MET as evidenced by: Based on record review and interview the home health agency failed to conduct exercises to test the emergency plan annually and included a full scale exercise that was community-based every 2 years. Findings include: Record review evidenced an undated agency policy received 11/17/2022 titled, “Emergency Disaster Plan Orientation and Training” which stated, “… emergency disaster preparedness training will be provided at least every 2 years … the agency must conduct exercises to test the emergency plan at least annually ... participate in a full-scale exercise that is community based; or … conduct an annual individual, agency based functional exercise every 2 years ….” Review of the emergency preparedness binder on 11/14/2022 failed to evidence a community based or facility wide testing since 2019. During an interview on 11/14/2022, at 11:40 AM, the alternate administrator indicated there has not been a community based emergency plan or facility wide testing since 2019.	E0039		
G0000	INITIAL COMMENTS This survey was a 2nd Post Condition Revisit for a Re-certification and Emergency Preparedness survey of a home health agency.	G0000		

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G0000	Continued from page 22 Survey Dates: 11/14/2022 – 11/17/2022 Facility ID: IN006389 Active Census: 6 During this survey, 3 condition level citations remain, and 4 new condition level citations were cited. Seven (7) standards were corrected, and 14 standards were recited. Twenty-three (23) new standards were added. During this Federal Recertification Survey, Healthmasters Inc. was found to be out of compliance with Conditions of Participation 42 CFR 484.45 Reporting OASIS Information; 42 CFR §484.55: Comprehensive Assessment of Patients; 42 CFR §484.60: Care Planning, Coordination of Services, and Quality of Care; 42 CFR §484.65 Condition: Quality Assessment / Performance Improvement; 42 CFR §484.80 Home Health Aide Services; and 42 §CFR 484.105 Organization and Administration of Services. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Based on the condition-level deficiencies during the 6/13/2022 survey, Healthmasters, Inc. is precluded from providing its own home health aide training and competency evaluation for a period of two years which began on 06/13/2022 through 06/12/2024. Quality Review Completed 12/07/2022	G0000		
G0370	Reporting OASIS information CFR(s): 484.45 Condition of participation: HHAs must electronically report all OASIS data collected in accordance with §484.55. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the agency failed to electronically report and transmit an OASIS (Outcome and Assessment Information Set) assessment in 2 of 2 clinical records reviewed	G0370		

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G0370	Continued from page 23 receiving skilled nursing services. (#1, 3) This practice has the potential to affect all patients. The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.45 Reporting OASIS information. The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled “Encoding and Reporting OASIS Data” stated, “… Agency will encode and electronically transmit each completed OASIS assessment to the CMS [Centers for Medicare and Medicaid Services] system within 30 days of completing the assessment of the client….” 2. Review of an undated agency policy obtained 11/17/2022, titled “Comprehensive Client Assessment” stated, “… A thorough, well-organized, comprehensive and accurate assessment … will be completed for all clients in a timely manner, but no later than five (5) calendar days after start of care. All skilled Medicare and Medicaid clients except pediatric and post-partum will have comprehensive assessments that include the OASIS data set specific to mandated time points … but will be done at least once in every sixty (60) day period….” 3. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled “Home Health Plan of Care [and] Certification” for certification period 10/25/2022-12/23/2022, which indicated the agency was to provide skilled nursing services. Review failed to evidence OASIS assessment data was electronically reported and transmitted to the CMS system since the patient’s admission to the agency. 4. Clinical record review on 11/17/2022, for Patient #3, start of care 8/30/2022, evidenced an agency document titled “Home Health Plan of Care [and] Certification” for certification period 10/29/2022-12/27/2022, which indicated the agency was to provide skilled nursing services. Review failed to evidence assessment data was electronically reported and transmitted to the CMS system since the patient’s admission to the agency.	G0370		

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G0370	Continued from page 24 5. During an interview on 11/16/2022, at 12:43 PM, the administrator indicated she did not know how transmission of the OASIS information was reported or who did the transmission. 6. During an interview on 11/16/2022, at 12:45 PM, the alternate administrator indicated the agency was behind 5 or 6 months regarding the transmission of OASIS information. Documentation was requested regarding the most recent OASIS transmissions. O 7. During an interview on 11/17/2022, at 11:46 PM, the alternate administrator indicated he did not have any documentation regarding the transmission of OASIS information.	G0370		
G0434	Participate in care CFR(s): 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the patients had the right to participate in, be informed of, and consent to care in advance of treatment in 2 of 2 clinical records reviewed without a current plan of care. (#5, 6)	G0434		

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G0434	Continued from page 25 The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled “Home Care Bill of Rights” stated, “… A designated Registered Nurse/Therapist shall provide the client with a written notice of the Home Care Bill of Rights in advance of furnishing care to the client ….” 2. Clinical record review on 11/15/2022, for Patient #5, start of care 2/23/2013, failed to evidence the patient’s consent to treatment. 3. Clinical record review on 11/15/2022, for Patient #6, start of care 4/23/2013, failed to evidence the patient’s consent to treatment. 4. During an interview on 11/17/2022, at 11:04 AM, when queried where were the patients’ consents, the alternate administrator stated, “What is a consent?” The alternate administrator indicated the agency did not have patient consents but only the waiver information from the local Area of Aging. 410 IAC 17-12-3(b)(2)(D)(ii)(AA)	G0434		
G0510	Comprehensive Assessment of Patients CFR(s): 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. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the agency failed to provide a complete comprehensive assessment that included the patient’s health, psychosocial, functional, and cognitive status (see tag G528), review current medications (see tag G536), update the comprehensive assessment the last 5 days of every 60 days (see tag G546), update the comprehensive assessment within 48	G0510		

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G0510	Continued from page 26 hours of patient's return home from an admission of 24 hours or more (see tag G548). 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.	G0510		
G0528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the comprehensive assessment reflected the patient's current health status in 4 of 4 clinical records reviewed with a current comprehensive assessment. (#1, #2, #3, #4) The findings include: 1. Review of an undated agency policy obtained on 11/17/2022, titled "Comprehensive Client Assessment" stated, "… The Comprehensive Assessment must accurately reflect the client's status, and must include at a minimum, the following information: The client's current health, psychosocial, functional, and cognitive status…." 2. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled "OASIS Assessment Details" dated 10/24/2022, which indicated the patient had a gastrostomy (a surgically created hole in the abdomen and into the stomach to deliver nutrition, hydration, and/or medication) and a tracheostomy (a surgically created hole in the neck and into the windpipe to assist with breathing). Review failed to evidence the comprehensive assessment included an assessment of the gastrostomy and tracheostomy sites to include patency, color, drainage, and type and size of tracheostomy and gastrostomy tubes. During an interview on 11/17/2022, at 10:49 AM, the administrator indicated she did not know the type and size of the tracheostomy and indicated	G0528		

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G0528	Continued from page 27 the comprehensive assessment should include a complete assessment of the tracheostomy and gastrostomy sites. 3. Clinical record review on 11/14/2022, for Patient #2, start of care 7/17/2022, evidenced an agency document titled “OASIS [Outcome and Assessment Information Set] Assessment Details” and identified as the recertification assessment completed by the administrator and dated 11/13/2022. Review evidenced the assessment of the patient’s height and weight was blank. Review indicated the comprehensive assessment included the patient was assessed to not have injectable medications. Review of an agency document titled “Home Health Plan of Care [and] Certification” for certification period 9/15/2022-11/13/2022, which indicated the patient’s medications included, but were not limited to, cyanocobalamin (vitamin B12) via an intramuscular injection. During an interview on 11/16/2022, at 11:02 AM, the administrator indicated the agency cannot stand the patient up so the height and weight was not obtained and indicated she did not ask the patient/caregiver for the patient’s last known height and weight. The administrator indicated the patient does have an injectable medication and the comprehensive assessment was not correct. 4. Clinical record review on 11/15/2022, for patient #3, start of care 08/30/2022, evidenced an agency document titled, “Oasis Assessment Details” for certification period 10/29/22-12/27/22. This document indicated the patient's weight was at 65 pounds. Review evidenced Hospital A document dated 10/29/2022, which indicated patient’s weight was 162 pounds 6.4 ounces. Review evidenced Doctor B document dated 11/16/2022, which indicated patient’s weight was 162 pounds. Review failed to evidence the patient’s complete current health status. During an interview on 11/16/2022, at 12:45 PM, the clinical supervisor indicated 65 pounds was the correct weight. The clinical supervisor indicated the weight was done at the doctor’s	G0528		

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G0528	Continued from page 28 office due to unable to weigh patient at home. During an interview on 11/16/2022, at 12:50 PM, LPN (licensed practical nurse) #2 indicated it was unknown where the weight came from on the comprehensive assessment due to unable to weigh patient at home. LPN #2 indicated the patient's weight fluctuates and indicated the patient will look smaller. LPN #2 indicated the doctor was not notified if weight or diet changes. LPN #2 indicated patient was able to have oral intake of a normal diet. Review evidenced an agency document titled, "Oasis Assessment Details" for certification period 10/29/2022-12/27/2022, in subsection "Gastrointestinal Status" failed to evidence peg tube (feeding tube in the stomach) enteral feeding formula, amount, frequency, size of peg tube or assessment of site. Review evidenced an agency document titled, "Home Health Plan of Care and Certification" for certification period 10/29/2022-12/27/2022 which indicated the patient had a peg tube. During an interview on 11/16/2022, at 12:20 PM, the clinical supervisor indicated she was unsure if there was a formula for enteral feedings, and stated she thinks the peg tube was for medication only due to the patient eats. During an interview on 11/17/2022, at 10:40 AM, the clinical supervisor indicated the peg tube care, formula for enteral feedings/site evaluation should be included on the comprehensive assessment. During an interview on 11/16/2022, at 12:50 PM, LPN (licensed practical nurse) #2 indicated the patient is receiving the formula Nutren for the enteral feeding. 5. Clinical record review on 11/14/2022, for patient #4, start of care 07/16/2022, evidenced an agency document titled, "Oasis Assessment Details" for certification period 11/13/2022-01/11/2023. This document had subsection titled, "Gastrointestinal Status" which stated within normal limits, the "Enteral Feeding" section was blank. Review evidenced an agency document titled, "Home Health Plan of Care and Certification" for	G0528		

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G0528	Continued from page 29 certification period 11/13/2022-01/11/2023. This document under subsection titled, "DME and Supplies:" stated feeding tube, and under subsection titled, "Medications:" indicated medications via peg tube. During an interview on 11/16/2022, at 12:00 PM, the clinical supervisor indicated there are no formula enteral feedings, the peg tube was for medication only and patient was on a regular diet. The clinical supervisor indicated the patient's mother addressed the flushes of the peg tube. During an interview on 11/17/2022 at 10:40 AM, the clinical supervisor indicated the comprehensive assessment should include peg tube information. 410 IAC 17-14-1(a)(1)(B)	G0528		
G0536	A review of all current medications CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to include in the comprehensive assessment a medication review to identify drug duplication, interactions, and side effects in 6 of 6 clinical records reviewed (#1, #2, #3, #4, #5, #6) Findings include: 1. Record review evidenced an undated agency policy received on 11/17/2022, titled “Medication Profile” stated “… medical profile should document ... medication name, medication dosage, route and frequency of administration, contraindications ... side effects … if the physician changes the medication orders, the nurse must add newly ordered drugs to the medication profile … the medication profile shall be reviewed by a registered nurse every 60 days and updated whenever there is a change or discontinuation in medication. The registered nurse shall sign and date the medication profile upon initiation and at	G0536		

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G0536	Continued from page 30 minimum every 60 days thereafter ….” 2. Record review evidenced an undated agency policy received on 11/17/2022, titled “Comprehensive Client Assessment” stated “… the comprehensive assessment … will have a review of all medications … to identify any potential adverse effects and significant drug reactions … significant drug interactions, duplicate drug therapy ….” 3. Clinical record review for patient #3 on 11/15/2022, start of care 08/20/2022, evidenced an undated agency document for admission date 08/30/2022, titled, “Medication Profile” that stated, “… Excedrin migraine [pain reliever] oral tablet 250/250/65 MG [milligram] PRN [as needed] feeding tube … Tylenol [pain reliever] PRN 1 tab feeding tube…Tylenol 160mg/ml [milliliter] Elix every 4 hours PRN … Tylenol extra strength oral solution 160mg/5ml PRN feeding tube…Tylenol Extra Strength oral solution 160mg/5 ml g-tube … Tylenol for children/adults oral suspension 160mg/5ml every 6 hours PRN one tsp [teaspoon] g tube ….” This document failed to evidence duplicate drug therapy was addressed. Review evidenced an agency document titled, “Medication Profile” for admission date 08/30/2022. This document failed to evidence a registered nurse signature or date reviewed. During an interview on 11/16/2022, at 12:15 PM, the clinical supervisor indicated all of the Tylenol should not be on the medication profile. The clinical supervisor indicated the physician should be notified if duplicate medication was noted. At 11:40 AM, the clinical supervisor indicated if the medication profile was not signed there was no documentation when the medication profile was reviewed. The clinical supervisor also indicated the medication profile was updated only if the doctor changed medications. During an interview on 11/16/2022, at 12:50 PM, LPN (licensed practical nurse) #2 indicated that she does not give Tylenol and the PRN was up to the family. LPN #2 was unsure if the patient was receiving Tylenol and unsure if the family knew the maximum dose of Tylenol daily. 4. Clinical record review for patient #4 on 11/14/2022, start of care 07/16/2022, evidenced an agency document titled, “Home Health Plan of Care	G0536		

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G0536	Continued from page 31 and Certification" for certification period 11/13/2022-01/11/2023 which stated, " "... Diphenhydramine [antihistamine]12.5mg/5ml 4 times daily as need prn … q dryl [antihistamine] 12.5mg/5ml 5 ml 4 times a day … Tramadol [pain reliever] 5mg/ML 3 times daily as needed for pain …." This document failed to evidence duplicate drug therapy was addressed and failed to evidence a dosage for Tramadol. Review evidenced the last signed medication profile was dated 11/20/2019. During an interview on 11/16/2022, at 12:00 PM, the clinical supervisor indicated Alora (electronic medical records) does not check for duplicate medication. The clinical supervisor indicated 2 antihistamines were ordered by the doctor and they follow the doctor's order. The clinical supervisor indicated the patient's mother kept the medications and notified the agency of medication changes. The clinical supervisor indicated the PRN indication for diphenhydramine should be PRN for pain. The clinical supervisor indicated she doesn't know why the patient was on q dryl and diphenhydramine. The clinical supervisor indicated she doesn't know what the dose of Tramadol should be, but probably 5mg. The clinical supervisor indicated if the medication profile was not signed there was no documentation when the medication profile was last reviewed. The clinical supervisor indicated the medication profile should be updated in Alora when there was a change in medication and indicated the doctor should be notified if duplicate medication was noted. 5. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled "Home Health Plan of Care [and] Certification" for certification period 10/25/2022-12/23/2022, which indicated the patient's medications included, but were not limited to, protonix (a medication used to treat reflux), furosemide (a medication used to remove excess fluid from the body), alprazolam (a medication used to treat anxiety, and budesonide (a steroid medication used to treat inflammation). Review failed to evidence a medication profile signed by the registered nurse since the patient's admission on 6/27/2022 and failed to evidence the medications were reviewed by the registered nurse. Review evidenced an agency document titled	G0536		

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G0536	Continued from page 32 "Skilled Nursing Visit Note" dated 11/14/2022, which indicated the patient was diagnosed with chest congestion and prescribed an unidentified medication. Review of a document dated 11/14/2022, from the patient's physician titled "Office Visit" indicated the patient was prescribed prednisone (a steroid used to treat inflammation) for 8 days beginning on 11/14/2022. Review failed to evidence the prednisone was included on the medication profile and was reviewed for drug interactions and side effects. During an interview on 11/16/2022, at 11:51 AM, the clinical manager indicated she was not aware of the new prednisone order. Review of agency document titled "Skilled Nursing Visit Note" dated 10/13/2022, indicated the physician gave a verbal order for Robitussin (a medication used to treat cough). Review failed to evidence the Robitussin was entered on to the medication profile and reviewed for drug interactions and side effects. 6. Clinical record review on 11/14/2022, for Patient #2, start of care 7/17/2022, evidenced an agency document titled "Home Health Plan of Care [and] Certification" for certification period 11/14/2022-1/12/2023, which indicated the patient's medications included, but were not limited to, coumadin (a medication used to thin the blood to treat and/or prevent blood clots), cyanocobalamin (vitamin B12), protonix (a medication used to treat reflux), baclofen (muscle relaxer), lisinopril (a medication used to treat high blood pressure), and Cymbalta (medication used to treat depression and/or nerve pain). Review failed to evidence a medication profile signed by the registered nurse since the patient's admission on 7/17/2022, and failed to evidence the medications were reviewed for side effects and drug interactions. 7. Clinical record review on 11/15/2022, for Patient #5, start of care 2/23/2013, evidenced an undated agency document titled "Medication Profile Summary". Review indicated the patient's medications included, but were not limited to, hydralazine (a medication used to treat high blood pressure), nitroglycerin (a medication used to treat chest pain), and doxazosin (a medication used to relax the bladder). Review failed to	G0536		

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G0536	Continued from page 33 evidence a signed medication profile and failed to evidence the medications were reviewed for side effects and drug interactions. 8. Clinical record review on 11/15/2022, for Patient #6, start of care 4/22/2013, evidenced an agency document titled “Medication Profile” dated 11/16/2019. Review indicated the patient’s medications included, but were not limited to, apixaban (a medication used to thin the blood to treat and/or prevent blood clots), Cymbalta, Norvasc (a medication used to treat high blood pressure), and divalproex (a medication used to treat seizures). Review failed to evidence the agency reviewed the patient’s medications since 11/16/2019. During an interview on 11/17/2022, at 10:56 AM, the clinical manager indicated she had not seen the patient in a while to review the medications. 9. During an interview at the entrance conference on 11/14/2022, at 10:31 AM, the administrator indicated new medications should be entered on to the medication profile in the electronic medical record and the drug review would be conducted automatically by the electronic medical record. 410 IAC 17-14-1(a)(1)(B)	G0536		
G0546	Last 5 days of every 60 days unless: CFR(s): 484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to update the comprehensive assessment within the last 5 days of every 60 days beginning with the start of care date in 2 of 2 clinical records reviewed without a current plan of care. (#5, 6) The findings include:	G0546		

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G0546	Continued from page 34 1. Review of an undated agency policy obtained 11/17/2022 titled “Comprehensive Client Assessment” stated, “… The depth and frequency of ongoing assessments … will be done at least once in every sixty (60) day period….” 2. Clinical record review on 11/15/2022, for Patient #5, start of care 2/23/2013, failed to evidence a comprehensive assessment was completed since 7/18/2022. 3. Clinical record review on 11/15/2022, for Patient #6, start of care 4/22/2013, failed to evidence a comprehensive assessment was completed since 5/14/2020. 4. During an interview on 11/17/2022, at 10:45 AM, the alternate administrator indicated the agency did not conduct updated comprehensive assessments for patients #5 and #6 because the patients did not have a current plan of care. 410 IAC 17-14-1(a)(1)(B)	G0546		
G0548	Within 48 hours of the patient's return CFR(s): 484.55(d)(2) Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician or allowed practitioner - ordered resumption date; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to update the patient’s comprehensive assessment within 48 hours of the patient’s return to the home from the hospital admission of 24 hours or more in 2 of 2 records reviewed with hospitalizations. (#1, #3) Findings include: 1. Record review evidenced an undated agency policy received 11/17/2022, titled, “Client Reassessment/Update of Comprehensive Assessment” which stated “… the comprehensive assessment will be updated within 48 hours of client return home from hospital admission of more than 24 hours … clients are reassessed when significant changes occur in their diagnosis ….”	G0548		

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G0548	Continued from page 35 2. Clinical record review for patient #3 on 11/15/2022, start of care 08/30/2022, evidenced an agency document titled, “Oasis [Outcome and Assessment Information Set] Assessment Details,” for certification period 10/29/2022-12/27/2022, completed on 10/28/2022, that stated, “assessment being completed for recertification ….” This document failed to evidence the comprehensive assessment was updated after hospitalization from 10/29/2022-11/03/2022. Review of a document dated 10/29/2022 from Hospital A indicated a diagnosis of septic shock and emergency cystoscopy left ureteral stent placement upon admission 10/29/2022. This document indicated the patient was discharged on 11/03/2022. During an interview on 11/16/2022, at 1:00 PM, the clinical supervisor indicated the comprehensive assessment was only updated the last 5 days of a 60 day recertification period. The clinical supervisor indicated the comprehensive assessment was not updated for change in condition or admission to a new facility. 3. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled “OASIS Assessment Details” dated 10/24/2022, which indicated the patient was admitted to the hospital on 10/14/2022, with a diagnosis of pneumonia. Review of an agency document titled “Skilled Nursing Visit Note” electronically signed by LPN [licensed practical nurse] #1 and dated 10/19/2022, indicated the agency provided skilled nursing services. During an interview on 11/15/2022, at 2:10 PM, Licensed Practical Nurse #1 indicated the patient was hospitalized for 5 days. Review failed to evidence the agency updated the comprehensive assessment within 48 hours of the return home after the hospital admission. During an interview on 11/17/2022, at 11:04 AM, the administrator indicated the patient was hospitalized and stated the agency “just went with the old assessment”.	G0548		
G0564	Discharge or Transfer Summary Content	G0564		

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G0564	Continued from page 36 CFR(s): 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the patient's transfer summary was sent to the receiving facility upon admission in 2 of 2 clinical records reviewed with hospitalization. (#1, #3) Findings include: 1. Record review evidenced an undated agency policy received on 11/17/2022, titled, "Client Transfer" stated "… a transfer summary to be completed by the registered nurse … include current medications … summary of care … current medications … the transfer summary shall be sent to the new provider or facility and a copy shall be retained for the client's chart ...." 2. Record review evidenced an undated agency policy received on 11/17/22, titled, "Medication Reconciliation" which stated "... if a client is admitted to an inpatient setting while receiving home care services, a list of current medications will be sent to the admitting facility …." 3. Clinical record review for patient #3 on 11/15/2022, start of care 08/30/2022, evidenced a document from Hospital A dated 10/29/2022 which indicated the patient was admitted on 10/29/2022. Review failed to evidence documentation of a transfer summary sent to hospital A upon patient's admission on 10/29/2022. During an interview on 11/16/22, at 12:45 PM, the clinical supervisor indicated a summary was not sent to the hospital when patient was admitted on 10/29/2022. 4. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an	G0564		

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G0564	Continued from page 37 agency document titled “OASIS [Outcome and Assessment Information Set] Assessment Details” dated 10/24/2022, which indicated the patient was admitted to the hospital on 10/14/2022, with a diagnosis of pneumonia. During an interview on 11/15/2022, at 2:10 PM, Licensed Practical Nurse (LPN) #1 indicated the patient was hospitalized for 5 days. Review failed to evidence a transfer summary was sent to the hospital. During an interview on 11/17/2022, at 11:04 AM, the administrator indicated no transfer summary was sent to the hospital.	G0564		
G0570	Care planning, coordination, quality of care CFR(s): 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. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the patient received a written plan of care which was reviewed and signed by the physician and received the home health services that are written in an individualized plan of care (see tag G572); the plan of care failed to be individualized and include the required items (see tag G574); drugs, services and treatments are administered only as ordered by a physician (see tag G580); failed to ensure verbal orders were	G0570		

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G0570	Continued from page 38 documented in the clinical record (see tag G584); failed to notify the physician of changes in the patient's status (see tag G590); failed to revised the plan of care with pertinent changes (see tag G592); failed to communicate with all physicians involved in the patient's plan of care (see tag G602); and failed to coordinate care with disciplines involved in the patient's care (see tag G606). Findings: The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR §484.60: Care Planning, Coordination of Services, and Quality of Care. 410 IAC 17-13-1(a)	G0570		
G0572	Plan of care CFR(s): 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the development of written, individualized plans of care for each patient which were established and reviewed and signed by a physician and failed to provide the services as directed in the plan of care in 5 of 6 clinical records reviewed. (#1, 2, 4. 5, 6) The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled "Plan of Care" stated, "… Home care services are furnished under the supervision	G0572		

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G0572	Continued from page 39 and direction of the client's physician … Planning for care is a dynamic process that addresses the care, treatment and services to be provided … An individualized Plan of Care signed by a physician … shall be required for each client receiving home health and personal care services…." 2. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled "Home Health Plan of Care [and] Certification" for certification period 10/25/2022-12/23/2022, which indicated the patient was to receive oxygen via the tracheostomy (a surgically created hole in the neck and into the windpipe to assist with breathing) at 3 liters per minute continuously. Review evidenced agency documents titled "Skilled Nursing Visit Note" electronically signed by the licensed practical nurse (LPN) and dated 11/9/2022, 11/10/2022, 11/11/2022, 11/12/2022, and 11/14/2022, which indicated the patient was receiving 2 liters per minute of oxygen. Review failed to evidence the nurse provided the services to the patient as directed in the plan of care. During an interview on 11/16/2022, at 11:51 AM, the administrator indicated if the patient's needs required something different than as ordered in the plan of care, the agency should contact the physician for clarification and update the plan of care. 3. Clinical record review on 11/14/2022, for Patient #2, start of care 7/17/2022, evidenced an agency document titled "Home Health Plan of Care [and] Certification" for certification period 9/15/2022-11/13/2022, which indicated the nurse would notify the physician of a systolic blood pressure (the pressure against the arteries when the heart contracts, noted by the top number) less than 100. Review of an agency document titled "OASIS [Outcome and Assessment Information Set] Assessment Details" and identified as the recertification assessment completed by the administrator dated 11/13/2022, indicated the patient's blood pressure was 97/84. Review failed to evidence the nurse notified the physician of the systolic blood pressure outside of normal parameters as directed in the plan of care. During an interview on 11/16/2022, at 11:02 AM,	G0572		

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G0572	Continued from page 40 the administrator indicated she did not notify the physician. 4. Clinical record review on 11/15/2022, for Patient #5, start of care 2/23/2013, evidenced agency documents titled “Aide Visit Note” dated 10/21/2022, 10/24/2022, 10/26/2022, 10/28/2022, 10/31/2022, 11/2/2022, 11/4/2022, 11/7/2022, 11/9/2022, 11/11/2022, and 11/14/2022. Review indicated the home health aide assisted the patient with personal care and activities of daily living (ADL). Review failed to evidence a plan of care since certification period ended on 9/13/2020. 5. Clinical record review on 11/15/2022, for Patient #6, start of care 4/23/2013, evidenced agency documents titled “Aide Visit Note” dated 10/21/2022, 10/24/2022, 10/26/2022, 10/28/2022, 10/31/2022, 11/2/2022, 11/4/2022, 11/7/2022, 11/9/2022, 11/11/2022, and 11/14/2022. Review indicated the home health aide assisted the patient with personal care and ADLs. Review failed to evidence a plan of care since certification period ended on 5/14/2020. 6. During an interview on 11/14/2022, at 2:07 PM, the alternate administrator indicated there were no current plans of care for Patient #5 and Patient #6 because neither patient had a physician. The alternate administrator indicated the agency did not have any physician orders for either patient. The alternate administrator indicated the agency should have discharged the patients but did not. 7. Clinical record review of patient #4 on 11/14/2022, start of care 07/16/2022, evidenced an agency document titled, “Home Health Plan of Care and Certification” for certification period 11/13/2022-01/11/2023 which indicated skilled nurse visits monthly for home health aide supervision. Review failed to evidence supervisory visits were completed monthly. During an interview on 11/16/2022, at 12:00 PM, the clinical supervisor indicated the supervisory visits are done every 50-60 days and the plan of care should say every 50-60 days not every 30 days. 410 IAC 17-13-1(a)	G0572		
G0574	Plan of care must include the following	G0574		

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G0574	Continued from page 41 CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the plans of care were developed to meet the individual needs of each patient and	G0574		

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G0574	Continued from page 42 included all medications, services, treatments, and medical supplies required in 4 of 4 clinical records reviewed with current plans of care. (#1, 2, 3, 4) The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled “Plan of Care” stated, “… The Plan of Care is based on a comprehensive assessment and information provided by the client/family … agency staff to develop a plan of care individualized to meet specific identified needs … The Plan of Care shall be completed in full to include … Type, frequency, and duration of all visits/services … Specific dietary or nutritional requirements or restrictions … Medications, treatments, and procedures … Medical supplies and equipment required ….” 2. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled “OASIS [Outcome and Assessment Information Set] Assessment Details” dated 10/24/2022, which indicated the patient’s diagnoses included Down Syndrome and cerebral palsy and indicated the patient was dependent for care. Review indicated the patient had a tracheostomy (a surgically created hole in the neck and into the windpipe to assist with breathing) and a gastrostomy (a surgically inserted tube into the stomach through the abdomen to deliver nutrition, hydration, and/or medication). Review indicated the patient was NPO (not able to take anything by mouth). Review evidenced an agency document titled “Home Health Plan of Care [and] Certification” for certification period 10/25/2022-12/23/2022, which indicated the agency was to provide skilled nursing services 7 days a week. Review failed to evidence the plan of care included orders for the skilled nursing services related to the care of the gastrostomy, tracheostomy, and medication administration. Review indicated the patient’s medications included, but were not limited to, acetaminophen (a medication used to treat pain and/or fever) as needed, alprazolam (a medication used to treat anxiety) as needed, and bacitracin (an antibacterial ointment) as needed. Review failed to evidence the plan of care was complete and individualized to include the indications for as needed use of acetaminophen, alprazolam, and bacitracin. Review failed to evidence the	G0574		

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G0574	Continued from page 43 frequency of the bacitracin administration. Review indicated the patient was NPO and received medications via the gastrostomy tube. Review indicated potassium chloride (mineral supplement) should be administered by mouth. Review indicated the patient's supplies included a urinary ostomy (a surgically created hole in the abdomen to drain urine from the body). Review failed to evidence the plan of care included the patient's NPO status. During an interview on 11/16/2022, at 1:43 PM, the administrator indicated the plan of care should include the frequency and indications of use for the medications and indicated the plan of care should include the potassium chloride was to be administered via the gastrostomy tube. During an interview on 11/16/2022, at 11:51 AM, the administrator indicated the plan of care should include orders for whatever the nurse does for the patient to include care of the gastrostomy and tracheostomy and medication administration. The administrator indicated the patient did not have a urinary ostomy. 3. Clinical record review on 11/14/2022, for Patient #2, start of care 7/17/2022, evidenced agency documents titled "Home Health Plan of Care [and] Certification". Review of the plan of care for certification period 9/15/2022-11/13/2022 indicated the nurse was to draw monthly PT/INR labs (a blood test to determine the time it takes for the blood to clot) and administer cyanocobalamin (vitamin B12) through an intramuscular injection. Review failed to evidence the nurse obtained PT/INR labs and administered cyanocobalamin during the certification period of 9/15/2022-11/13/2022. Review of the plan of care for certification period 11/14/2022-1/12/2023 indicated the patient's medication included ocrelizumab (a medication used to treat multiple sclerosis, a disease in which the body attacks the protective covering of nerve cells). Review failed to evidence the dose and frequency of the medication. Review indicated the patient's supplies included a urinary ostomy. During an interview on 11/16/2022, at 10:56 AM, the administrator indicated she did not know how much and how often the patient received ocrelizumab because the patient received this medication at the hospital. The administrator indicated the patient did not have a urinary	G0574		

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G0574	Continued from page 44 ostomy and was unsure why the plan of care included a urinary ostomy. The administrator indicated the nurse was not needed to obtain the PT/INR lab and administer the cyanocobalamin injection because these were changed to be completed at the hospital and indicated they should have been removed from the plan of care. 4. Clinical record review of patient #3 on 11/15/2022, start of care 08/30/2022, evidenced an agency document titled, “Home Health Plan of Care and Certification” for certification period 10/29/2022-12/27/2022 which stated, “ DME [durable medical equipment] and Supplies: Wheelchair, Hospital Bed, Sterile Gloves; Nutritional Requirements: peg tube (feeding tube into stomach); Safety Measure: Anticoagulant Precautions.” This document failed to evidence peg tube supplies and nutritional requirements including diet oral or enteral. This document’s medications failed to reveal patient was on an anticoagulant. Clinical record review evidenced an agency document dated 11/04/2022, titled, “Skilled Nursing Visit Note” which stated diet was soft, regular and tube feeding of Nutren (feeding tube formula) 375 milliliters intermittent. During an interview on 11/16/2022, at 12:20 PM, the clinical supervisor indicated peg tube supplies should be on the plan of care. The clinical supervisor indicated she did not know if the patient was on anticoagulation therapy. The clinical supervisor indicated the patient does not have enteral feedings due to the patient’s oral intake. During an interview on 11/16/2022, at 12:50 PM, LPN #2 indicated the patient had Nutren peg tube feedings. Review evidenced an agency document titled, “Home Health Plan of Care” for certification period 10/29/2022-12/27/2022, which stated, “… Mupirocin [topical skin treatment] 2% 2 times a day PRN [as needed] … Phenergan [treat nausea or allergy symptoms] rectal suppository 25mg 1 suppository…Tegretol [anticonvulsant] suspension 100milligrams/5 ml [milliliters] 3 times a day-ml-…Excedrin [pain reliever] migraine 250/250/65 ml PRN ….” This document failed to evidence frequency for Phenergan, and Excedrin, dose for Tegretol and Excedrin, and indications	G0574		

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G0574	Continued from page 45 for Mupirocin, Phenergan and Excedrin. During an interview on 11/16/2022, at 12:10 PM, the clinical supervisor indicated the Phenergan should be daily but was not documented. The clinical supervisor indicated the Tegretol dose was unknown. The clinical manager did not respond when queried of dose, frequency, or indication of Excedrin. 5. Clinical record review of patient #4 on 11/14/2022, start of care 07/16/2022, evidenced an agency document titled, “Home Health Plan of Care and Certification” for certification period 11/13/2022-01/11/2023, which indicated nutritional requirements and stated “none”. A section titled "Medications" indicated the patient received medications per peg tube (feeding tube in stomach). This document failed to evidence if the patient’s nutrition/diet was enteral or oral. During an interview on 11/16/2022, at 12:00 PM, the clinical supervisor indicated the patient does not receive formula feedings through the peg tube, the peg tube was for medications only. The clinical supervisor indicated the patient was on a regular diet. 410 IAC 17-13-1(a)(1)(D)(ii, viii, ix, xiii)	G0574		
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the patient’s drugs, services and treatments were administered only as ordered by a physician in 2 of 2 clinical records reviewed with skilled nursing services. (#1, 3) Findings include: 1. Record review evidenced an undated agency policy received on 11/17/2022 titled, “Plan of Care” which stated “… a signed plan of care by a physician shall be required for each client receiving home health … the plan of care shall	G0580		

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G0580	Continued from page 46 include specific dietary or nutritional requirements … medications, treatments, and procedures … medical supplies and equipment required ….” 2. Clinical record review on 11/15/2022 for patient #3, start of care 08/30/2022, evidenced an agency document dated 11/08/2022 titled, “Skilled Nursing Visit Note” which indicated “gastrointestinal" 375 ml (milliliters) Nutren (feeding tube formula) intermittent. The record failed to evidence a physician order which included how much of what nutritional formula was to be provided to the patient. Review evidenced an agency document titled, “Home Health Plan of Care and Certification” which failed to evidence specific dietary requirements, peg tube (feeding tube into the stomach) site care, and peg tube flushes. During an interview on 11/16/2022, at 12:20 PM, the clinical supervisor indicated she was unsure of formula for peg tube feedings, the clinical supervisor stated the peg tube may be for medication only and no formula feedings at this time. During an interview on 11/16/2022, at 12:50 PM, LPN (licensed practical nurse) #2 indicated the patient received Nutren 375 ml via peg tube on her shift with 120 ml of water flush, but LPN #2 indicated she leaves at 6:00 PM and the family will give Nutren at 8:30 PM with 150 ml of water flush. LPN #2 indicated she knew what the enteral feeding schedule, amount of formula and flush amount per instructions from the family and not from the plan of care. LPN #2 indicated that 50 ml of water flush was given with medication via peg tube and the flush instructions were given to her by the family, but the instructions are not on the plan of care. LPN #2 indicated peg tube site was cleansed with antiseptic, LPN #2 indicated the instructions were not on the plan of care, but the family had everything set up. 3. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled “Skilled Nursing Visit Note” electronically signed by licensed practical nurse #1 and dated 11/14/2022, which indicated the nurse suctioned the patient. Record review failed to evidence physician orders for the suctioning of the patient to include the type of suctioning, at	G0580		

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G0580	Continued from page 47 what pressure, and at what frequency. Review indicated the nurse administered tube feedings and water flushes through the gastrostomy tube (a tube surgically inserted in the abdomen and into the stomach to deliver nutrition, hydration, and/or medication). Review failed to evidence the physician orders for the administration of tube feedings and flushes through the gastrostomy tube. Review indicated the nurse administered inhaled medications via nebulizer (a medical device that delivers medications through vapor for inhalation). Review indicated the nurse performed chest physiotherapy treatment (CPT, a technique to clear the airway by performing percussions to the chest wall to loosen up mucous). Review failed to evidence a physician order for the nurse to administer medications and perform CPT. Review indicated the nurse provided tracheostomy care and failed to evidence a physician order for the nurse to provide tracheostomy and gastrostomy care. During an interview on 11/15/2022, at 2:10 PM, LPN #1 indicated she provided tracheostomy and gastrostomy care daily and as needed by cleaning the area and applying a dry dressing. The LPN indicated she performed CPT manually after administering the patient's nebulizer treatments and as needed if the patient sounded "chunky" and "if [the patient] sounds like there is gunk in there." The LPN indicated she performed suctioning of the tracheostomy using a soft flexible suction catheter and was unsure of the pressure she used and indicated the suction machine was already plugged in and set. The LPN indicated she administered equal amounts of tube feeding formula and water through the gastrostomy tube 4 times a day. During an interview on 11/16/2022, at 1:55 PM, the administrator indicated there should be physician orders for suctioning, tube feedings/flushes, medication administration, CPT, and tracheostomy care. 410 IAC 17-13-1(a)	G0580		
G0584	Verbal orders CFR(s): 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies.	G0584		

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G0584	Continued from page 48 (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure verbal orders were documented in the clinical record in 1 of 1 clinical record reviewed with a tracheostomy (a hole surgically inserted into the neck and into the windpipe to assist with breathing). (#1) The findings include: Review of an undated agency policy obtained 11/17/2022, titled “Physician/Allowed Non-Physician Practitioner (NPP) Orders” stated, “… When the nurse or therapist receives a verbal order from the physician … he/she shall write the order as given … The verbal order shall verify that the order was taken and verified by documenting this on the form and signing the form….” Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled “Skilled Nursing Visit Note” electronically signed by Licensed Practical Nurse (LPN) #1 and dated 10/13/2022, which indicated the physician gave a verbal order for Robitussin (a medication used to treat cough). Review failed to evidence the nurse wrote the verbal order given by the physician for the Robitussin. During an interview on 11/15/2022, at 2:10 PM, LPN #1 indicated she did not write the order received by the physician. During an interview on 11/17/2022, at 10:58 AM, the administrator indicated there was not a written order for the Robitussin.	G0584		

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G0584	Continued from page 49 410 IAC 17-14-1(a)(2)(F)	G0584		
G0590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to promptly alert physician of changes in conditions that suggests the plan of care should be altered in 3 of 4 clinical records reviewed with current plans of care. (#1, 2, 3) Findings include: 1. Record review evidenced an undated agency policy received on 11/17/2022, titled “Medical Supervision” which stated “… Physician … will be contacted when ... condition changes ….” 2. Record review evidenced an undated agency policy received on 11/17/2022, titled “Medication Profile” which stated “… At the time of admission the admission professional shall check all medications … to identify … adverse reactions, significant side effects … and contraindicated medications. The clinician shall promptly report any identified problems to the physician ….” 3. Record review evidenced an undated agency policy received on 11/7/2022, titled, "Medication Reconciliation” which stated “... when client is discharged from the facility, the medications will be reviewed and the orders updated to reflect changes and/or continuation of previous orders … the admission professional will review medication list with the physician and confirm those medications that are to be continued or discontinued ….” 4. Clinical record review on 11/15/2022, for patient #3, start of care 08/30/2022, evidenced a Hospital A document dated 10/29/2022, which indicated patient was admitted to hospital on 10/29/2022.	G0590		

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G0590	Continued from page 50 Record review evidenced an agency document titled, “Skilled Nursing Visit Note” dated 10/29/2022. This document failed to evidence the physician was notified of the transfer to the hospital. During an interview on 11/16/2022, at 12:30 PM, the clinical supervisor indicated the patient was complaining of pain and the clinical supervisor instructed LPN (licensed practical nurse) #2 to send the patient to the emergency room. Record review evidenced an agency document titled, "Skilled Nursing Visit Note" which was dated 10/04/2022. This document indicated "Entapene" [sic] (antibiotic) to be given intravenously from 10/04/2022-11/13/2022. This document also indicated the patient was admitted to the hospital from 10/29/2022-11/04/2022. Record review evidenced a Hospital A document dated 10/29/2022, which indicated the patient was admitted from 10/29/2022-11/03/2022. This document indicated the patient was discharged from the hospital with the following medications: valproic acid, albuterol, lotrimin and botox injections. This document also indicated the patient would need a follow-up for stent change/removal within 3-6 months. Review 11/15/2022 evidenced an agency document titled, “Home Health Plan of Care and Certification” for certification period 10/29/2022-12/27/2022. This document failed to evidence valproic acid, albuterol, lotrimin or botox injections. Record review failed to evidence the plan of care was updated or reviewed with the primary care physician. During an interview on 11/16/2022, at 1:00 PM, the clinical supervisor indicated the plan of care was not updated for change in patient's condition during an admission. During an interview on 11/16/2022, at 12:15 PM, the clinical supervisor indicated the medication profile should be updated if the doctor changes medication. During an interview on 11/16/22, at 12:50 PM, LPN #2 indicated the patient had removal of kidney stones but was unsure of the procedure performed. 5. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an	G0590		

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G0590	Continued from page 51 agency document titled “OASIS [Outcome and Assessment Information Set] Assessment Details” dated 10/24/2022, which indicated the patient was admitted to the hospital on 10/14/2022 with a diagnosis of pneumonia. Review failed to evidence the agency notified the physician of the patient’s hospital admission. During an interview on 11/17/2022, at 11:01 AM, the administrator indicated she did not believe the physician was made aware of the patient’s hospitalization. 6. Clinical record review on 11/14/2022, for Patient #2, start of care 7/17/2022, evidenced agency documents titled “Home Health Plan of Care [and] Certification” for certification periods 9/15/2022-11/13/2022 and 11/14/2022-1/12/2023. Review indicated the patient’s medications included, but were not limited to, coumadin (a medication to thin the blood to treat/prevent blood clots) 7.5 milligrams (mg) every Monday, Tuesday, Wednesday, and Thursday and 5mg every Friday, Saturday, and Sunday. Review of a document titled “Office Visit” dated 9/22/2022, from the office of the patient’s physician responsible for the plan of care, indicated the patient’s coumadin dose was 8.5mg daily. Review failed to evidence the physician was notified of the discrepancy for the coumadin dose and need for clarification. During an interview on 11/16/2022, at 11:01 AM, the administrator indicated the patient had the PT/INR (blood tests to monitor the time it takes for the blood to clot to show the effectiveness of the coumadin) tested monthly at the hospital. The administrator indicated the agency did not request the lab results and was unaware if there had been any change to the coumadin dose. 410 IAC 17-13-1(a)(2)	G0590		
G0592	Revised plan of care CFR(s): 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the	G0592		

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G0592	Continued from page 52 HHA and patient in the plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the plan of care was revised to reflect changes in 2 of 2 clinical records reviewed with a hospitalization. (#1, 3) The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled “Plan of Care” stated, “…The plan of care will be … updated as necessary ….” 2. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled “OASIS [Outcome and Assessment Information Set] Assessment Details” dated 10/24/2022, which indicated the patient was admitted to the hospital on 10/14/2022 with a diagnosis of pneumonia. Review of an agency document titled “Skilled Nursing Visit Note” electronically signed by the nurse and dated 10/19/2022, indicated the patient was taking Levofloxacin (an antibiotic used to treat infection). Review of an agency document titled “Home Health Plan of Care [and] Certification” for certification period 8/26/2022 – 10/24/2022, failed to evidence the plan of care was revised to reflect the patient’s antibiotic therapy for pneumonia. During an interview on 11/17/2022, at 11:00 AM, the administrator indicated the plan of care should have been updated to reflect the patient’s antibiotic. 3. Clinical record review on 11/15/2022, for patient #3, start of care 08/30/2022, evidenced an agency document titled, “Home Health Plan of Care and Certification” for certification period 10/2920/22 to 12/27/2022. This document failed to evidence the plan of care was updated and the change to the patient’s health status was communicated to the primary care physician. Record review evidenced a document from Hospital A dated 10/29/2022, which indicated the patient was diagnosed with septic shock and admitted on 10/29/2022.	G0592		

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G0592	Continued from page 53 During an interview on 11/16/2022, at 1:00 PM, the clinical supervisor indicated the plan of care was not updated for the patient's change of condition.	G0592		
G0602	Communication with all physicians CFR(s): 484.60(d)(1) Assure communication with all physicians or allowed practitioners involved in the plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to communicate to all physicians involved in the plan of care in 1 of 1 clinical record reviewed with anticoagulant medication (medication used to thin the blood to prevent/treat blood clots). (#2) The findings include: Review of an undated agency policy obtained 11/17/2022, titled “Coordination of Client Services” stated, “… Agency will communicate with ALL physicians … who are writing orders regarding the plan of care….” Clinical record review on 11/14/2022, for Patient #2, start of care 7/17/2022, evidenced agency documents titled “Home Health Plan of Care [and] Certification” for certification periods 9/15/2022-11/13/2022 and 11/14/2022-1/12/2023. Review indicated the patient’s medications included, but were not limited to, coumadin (a medication to thin the blood to treat/prevent blood clots) 7.5 milligrams (mg) every Monday, Tuesday, Wednesday, and Thursday and 5mg every Friday, Saturday, and Sunday. Review of a document titled “Office Visit” dated 9/22/2022, from the office of the patient’s physician responsible for the plan of care, indicated the patient’s coumadin dose was 8.5mg daily and indicated the patient followed-up with Person C, physician, regarding the coumadin and PT/INR (blood tests to monitor the time it takes for the blood to clot to show the effectiveness of the coumadin), which was tested monthly. Review failed to evidence communication with Person C, physician, regarding the PT/INR lab results and coumadin dose change.	G0602		

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G0602	Continued from page 54 During an interview on 11/16/2022, at 11:01 AM, the administrator indicated the agency did not request the lab results and was unaware if there had been any change to the coumadin dose. 410 IAC 17-14-1(a)(1)(G)	G0602		
G0606	Integrate all services CFR(s): 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to coordinate services in 2 of 2 clinical records reviewed with services provided by a licensed practical nurse (LPN). (#1, 3) The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled “Coordination of Client Services” stated, “… The coordination of care is provided by all disciplines … Agency will integrate services … to assure … the coordination of care provided by all disciplines. … Involvement of the care team must be apparent in the record either in an electronic health record of [sic] a paper document….” 2. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled “Skilled Nursing Visit Note” electronically signed by the LPN and dated 11/14/2022, which indicated the patient had a physician’s appointment, was diagnosed with chest congestion, and prescribed an unidentified medication. Review failed to evidence the LPN coordinated care with the case manager regarding the new medication. During an interview on 11/16/2022, at 11:51 AM, the clinical manager indicated she was not aware of the chest congestion and new medication. 3. Clinical record review on 11/15/2022, for	G0606		

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G0606	Continued from page 55 patient #3, start of care 08/30/2022, evidenced an agency document dated 11/04/2022, titled, “Skilled Nursing Visit Note” which stated, “Entapene (sic) will be given 11/04/22-11/13/22 intravenously”. This document failed to evidence LPN (licensed practical nurse) #2 notified and documented the RN (registered nurse) was notified of the intravenous medication and the services were integrated with others involved in the patient’s care. During an interview on 11/16/2022, at 12:30 PM, the clinical supervisor indicated she was unaware if the doctor or hospital was giving the intravenous medication. During an interview on 11/15/2022, at 12:50 PM, LPN #2 indicated Hospital A was providing patient with intravenous therapy and the alternate administrator was notified via text message. During an interview on 11/16/2022, at 12:50 PM, the alternate administrator indicated he does not recall any antibiotic information being sent via text. During an interview on 11/17/2022, at 12:00 PM, LPN #2 clarified the patient received Ertapenem (antibiotic) intravenous via PICC (peripherally inserted central catheter) at Hospital A outpatient clinic. 410 IAC 17-12-2(g)	G0606		
G0640	Quality assessment/performance improvement CFR(s): 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors.	G0640		

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G0640	Continued from page 56 The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the quality assurance and performance improvement (QAPI) program failed to measure, analyze and track quality indicators and other aspects of performance that enable the agency to assess processes of care, agency services and operations (see tag G642); to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement (see G644); to focus on high risk areas (see tag G648); to conduct performance improvement projects (see G658); and to ensure the governing body was responsible for the implementation and maintenance of the QAPI program. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 42 CFR §484.65 Condition: Quality Assessment / Performance Improvement.	G0640		
G0642	Program scope CFR(s): 484.65(a)(1),(2) Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to show measurable improvements in indicators to improve health outcomes and quality of care.	G0642		

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G0642	Continued from page 57 The findings include: Review of an undated agency policy obtained 11/17/2022, titled “Quality Assessment and Performance Improvement (QAPI)” stated, “… The program will be capable of showing measurable improvement in indicators that will improve health outcomes, client safety, and quality of care….” Review of the agency’s QAPI program on 11/14/2022, failed to evidence data showing the measurable improvements in indicators related to the patient health outcomes and quality of care. During an interview on 11/14/2022, at 11:06 AM, the alternate administrator indicated the agency did not have any data related to measurable improvements in indicators. 410 IAC 17-12-2(a)	G0642		
G0644	Program data CFR(s): 484.65(b)(1),(2),(3) Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the QAPI (Quality Assessment Performance Improvement) program utilized data from the patients’ hospitalizations and infections to identify opportunities for improvement and monitor the quality of care.	G0644		

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G0644	Continued from page 58 The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled “Quality Assessment and Performance Improvement (QAPI)” stated, “… must ensure that the program … includes the use of emergency care services, hospital admissions … The agency will identify, measure, analyze, and track quality indicators … and other relevant data to assess processes of care, services ….” 2. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled “OASIS [Outcome and Assessment Information Set] Assessment Details” dated 10/24/2022, which indicated the patient was admitted to the hospital on 10/14/2022 with a diagnosis of pneumonia. During an interview on 11/15/2022, at 2:10 PM, LPN #1 indicated the patient was hospitalized for 5 days. 3. Clinical record review on 11/15/2022, for Patient #3, start of care 8/20/2022, evidenced a document from Hospital A titled “ED [Emergency Department] to Hosp [Hospital] Admission (Discharged)” dated 11/3/2022, which indicated the patient was admitted to the hospital on 10/29/2022 and discharged on 11/3/2022. Review indicated the patient had a diagnosis of sepsis (the body’s extreme response to an infection) and was discharged with antibiotics. 4. Review of the agency’s QAPI program on 11/14/2022, failed to evidence the identification and analysis of infections and hospitalizations. Review failed to evidence quality indicator data collection. 5. During an interview on 11/14/2022, at 11:06 AM, the alternate administrator indicated the agency had not developed any performance improvement activities related to the patient hospitalizations and infections. 410 IAC 17-12-2(a)	G0644		
G0648	High risk, high volume, or problem-prone area CFR(s): 484.65(c)(1)(i) (i) Focus on high risk, high volume, or	G0648		

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G0648	Continued from page 59 problem-prone areas; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the performance improvement activities focused on areas of high risk and high volume. The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled “Quality Assessment and Performance Improvement (QAPI)” stated, “… The agency’s performance improvement activities will focus on high risk, high volume, or problem prone areas that are specific to this agency….” 2. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled “OASIS [Outcome and Assessment Information Set] Assessment Details” dated 10/24/2022, which indicated the patient was admitted to the hospital on 10/14/2022 with a diagnosis of pneumonia. During an interview on 11/15/2022, at 2:10 PM, LPN #1 indicated the patient was hospitalized for 5 days. 3. Clinical record review on 11/15/2022, for Patient #3, start of care 8/30/2022, evidenced a document from Hospital A titled “ED [Emergency Department] to Hosp [Hospital] Admission (Discharged)” dated 11/3/2022, which indicated the patient was admitted to the hospital on 10/29/2022, and discharged on 11/3/2022. Review indicated the patient had a diagnosis of sepsis (the body’s extreme response to an infection) and was discharged with antibiotics. 4. Review of the agency’s QAPI program on 11/14/2022, failed to evidence performance improvement activities based on the patient hospitalizations and infections. 5. During an interview on 11/14/2022, at 11:06 AM, the alternate administrator indicated the agency had not developed any performance improvement activities related to the patient hospitalizations and infections.	G0648		
G0658	Performance improvement projects	G0658		

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G0658	Continued from page 60 CFR(s): 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure they had one performance improvement project either in development, ongoing or completed. The findings include: An undated agency policy received on 11/17/2022, titled, “Quality Assessment and Performance Improvement” stated, “... the agency must document the quality improvement projects undertaken, the reason for conducting these projects and the measurable progress achieve on these projects … the governing body is responsible for ensuring … an ongoing program for quality improvement and patient safety is defined, implemented, and maintained ….” Review of the quality assessment and performance improvement program on 11/14/2022 failed to evidence a performance improvement project. During an interview on 11/14/2022, at 11:05 AM, the alternate administrator indicated the performance improvement project was not put together yet.	G0658		
G0660	Executive responsibilities for QAPI CFR(s): 484.65(e)(1)(2)(3)(4) Standard: Executive responsibilities.	G0660		

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G0660	Continued from page 61 The HHA's governing body is responsible for ensuring the following: (1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained; (2) That the HHA-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness; (3) That clear expectations for patient safety are established, implemented, and maintained; and (4) That any findings of fraud or waste are appropriately addressed. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the governing body failed to ensure an ongoing program for quality improvement was implemented and maintained. The findings include: Review of an undated agency policy obtained 11/17/2022, titled “Quality Assessment and Performance Improvement (QAPI)” stated, “… The governing body is responsible for ensuring the following: … An ongoing program for quality improvement and patient safety is defined, implemented, and maintained….” Review of the agency’s QAPI program on 11/14/2022, failed to evidence the identification, collection, and analysis of quality indicators. Review failed to evidence performance improvement activities. During an interview on 11/14/2022, at 11:06 AM, the alternate administrator indicated the agency had patients with hospitalizations but did not have any data related to hospitalizations. The alternate administrator indicated the agency was still working on actions for the improvement of patient hospitalizations.	G0660		
G0684	Infection control	G0684		

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G0684	Continued from page 62 CFR(s): 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure they maintained a program for the surveillance, identification, prevention, control and investigation of infectious diseases. Findings include: 1. An undated agency document received 11/17/2022 titled, “Infection Control Surveillance” stated, “Agency will establish a continuous data monitoring and collecting system to detect infections or identify changes in infection trends ... an infection control log will be maintained ….” 2. An undated agency document received 11/17/2022 titled, “Infectious Disease Reporting” stated, “… infections … that will be reported include … urinary tract infections requiring physician intervention, upper or lower respiratory tract infections requiring physician intervention … when infections are identified and reported on the Infection Control Log, an investigation is conducted to determine possible causes … annually the agency will review the results of this surveillance, monitoring, and evaluation ….” 3. Clinical record review of patient #3 on 11/15/2022, start of care 08/30/2022, evidenced a	G0684		

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G0684	Continued from page 63 document from hospital A dated 10/29/2022 which indicated patient's diagnosis as septic shock, and patient was discharged on ertapenem (antibiotic) intravenously. Review failed to evidence the agency had identified or investigated the infection. During an interview on 11/16/2022, at 2:00 PM, the alternate administrator indicated there was not an infection log and indicated he did not know patient #3 had an infection. 4. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled “OASIS [Outcome and Assessment Information Set] Assessment Details” dated 10/24/2022, which indicated the patient was admitted to the hospital on 10/14/2022 with a diagnosis of pneumonia. Review of an agency document titled “Skilled Nursing Visit Note” electronically signed by the nurse and dated 10/19/2022, indicated the patient was taking an antibiotic. During an interview on 11/14/2022, at 11:06 AM, the administrator indicated none of the agency’s patients had any infections since September. During an interview on 11/17/2022, at 10:55 AM, when queried about what surveillance and tracking the agency had completed for the pneumonia infection, the alternate administrator indicated he would look for it. During an interview on 11/17/2022, at 11:10 AM, the alternate administrator indicated the agency did not have any documentation for the surveillance and tracking of the pneumonia infection.	G0684		
G0686	Infection control education CFR(s): 484.70(c) Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home	G0686		

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G0686	Continued from page 64 health agency failed to ensure staff was educated on infection control. The findings include: Review of an undated agency policy titled "Infection Control Plan" stated, "… Ongoing education will also be provided to employees … based on … state regulations and requirements of accrediting bodies…." Review of an agency document on 11/14/2022, titled "QAPI [Quality Assessment Performance Improvement] Performance Improvement Training" dated 10/8/2022, indicated the staff was provided with education on infection control procedures. Review of a document titled "QAPI Performance Improvement Training" dated 10/8/2022, evidenced the names and signatures of staff that attended the infection control training and failed to evidence the alternate clinical manager and Administrative Staff #4 were provided infection control education. During an interview on 11/17/2022, at 11:54 AM, the alternate administrator indicated all staff should receive infection control education.	G0686		
G0716	Preparing clinical notes CFR(s): 484.75(b)(6) Preparing clinical notes; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to accurately and completely prepare clinical notes in 2 of 2 clinical records reviewed with skilled nursing services. (#1, 3) The findings include: 1. Record review evidenced an undated agency policy received 11/17/2022 titled, "Clinical Documentation" which stated "… all skilled services provided by nursing … will be documented in the clinical record … additional information ... may be documented on the progress note …." 2. Record review evidenced an undated agency policy received 11/17/2022 titled, "Skilled Professional Services" which stated "… skilled	G0716		

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G0716	Continued from page 65 professionals must assume responsibility for … preparing clinical notes ….” 3. Clinical record review for patient #3 on 11/15/2022, start of care 08/30/2022 evidenced agency documents dated 10/28/2022, 11/04/2022, 11/05/2022 titled, “Skilled Nursing Visit Note” which failed to evidence pain assessment documentation. During an interview on 11/17/2022, at 10:40 AM, the clinical supervisor indicated pain should be assessed and documented at each nursing visit. Review evidenced an agency documented dated 11/0420/22 titled, “Skilled Nursing Visit Note." This visit note stated “... patient admitted hospital 10/29/2022-11/04/2022, right labia majoria [sic] swollen, right hand fingers swollen right arm swollen and bruised right foot and ankle and leg swollen and bruise on neck and right lower back.” Skilled Nurse Visit Notes dated 11/05/2022 and 11/08/2022 failed to evidence documentation of swelling and bruising noted on 11/04/2022. During an interview on 11/16/2022, 12:50 PM, LPN (licensed practical nurse) #2 indicated the physician was aware of the swelling and bruising because he saw the patient at the hospital and indicated she did not continue to document regarding swelling and bruising of skin on nursing notes because the bruising and swelling were improving. Review evidenced an agency document dated, 11/04/2022 titled, “Skilled Nursing Visit Note." Review of the nursing visit note indicated medications were unchanged and indicated "entapene" [sic] will be given 11/04/2022-11/13/2022 intravenously. This document failed to reveal correct name of intravenous antibiotic, who was administering the medication or intravenous access site assessment. During an interview on 11/16/2022, at 12:30 PM, the clinical supervisor indicated they were unsure if the doctor or hospital was administering patient's intravenous medication. During an interview on 11/16/2022, at 12:50PM, LPN #2 indicated hospital A was providing patient with intravenous therapy outpatient. On 11/17/2022 at 12:00 PM, LPN #2 called to update	G0716		

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G0716	Continued from page 66 intravenous antibiotic name was Ertapenem and indicated the patient had a PICC (peripherally inserted central catheter) line but line was taken out after intravenous antibiotics were completed. 4. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced agency documents titled “Skilled Nursing Visit Note” electronically signed by LPN #1 and dated 11/9/2022, 11/10/2022, 11/11/2022, 11/12/2022, and 11/14/2022, which indicated the patient was receiving 2 liters per minute of oxygen and failed to evidence the method of delivery. Review indicated the patient’s pulse oximetry (the measurement of oxygen in the patient’s blood) was 28%. Record review of documents dated 10/12/2022, 10/13/2022, 10/14/2022, 10/19/2022, 10/24/2022, 10/25/2022, 10/26/2022, 10/27/2022, 10/30/2022, 10/31/2022, 11/1/2022, 11/2/2022, 11/4/2022, 11/5/2022, 11/7/2022, 11/9/2022, 11/10/2022, 11/11/2022, 11/14/2022, and 11/15/2022 electronically signed by LPN #1 indicated the patient’s temperature was 97.0 degrees Fahrenheit, pulse was 68 beats per minute, respirations were 16 breaths per minute, and blood pressure was 100/70. During an interview on 11/15/2022, at 2:10 PM, LPN #1 indicated she carried over the temperature, pulse, respiration, and blood pressure from previous visits rather than document the correct vital signs for the patient because she was having problems with the electronic medical record program. During an interview with LPN #1 on 11/15/2022, at 2:10 PM, LPN #1 indicated the patient received oxygen at 28% and documented the pulse oximetry incorrectly due to a misunderstanding. The LPN indicated the patient received oxygen via the tracheostomy (a hole surgically created in the neck and into the windpipe to assist with breathing). 410 IAC 17-14-1(a)(2)(B)	G0716		
G0724	Supervise skilled professional assistants CFR(s): 484.75(c) Standard: Supervision of skilled professional assistants.	G0724		

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G0724	Continued from page 67 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the registered nurse (RN) failed to provide supervision of the licensed practical nurse (LPN) in 1 of 2 clinical records reviewed with services provided by a licensed practical nurse. (#1) The findings include: Review of an undated agency policy obtained 11/17/2022, titled “Licensed Practical Nurse Supervision” stated, “… The Agency shall provide Licensed Practical Nurse services under the direction and supervision … To assure the quality of services provided by the Licensed Practical Nurse. … To assess competency in the clinical skill and provide opportunity for review of plan ….” Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced agency documents titled “Skilled Nursing Visit Note” electronically signed by LPN #1 and dated 10/12/2022, 10/13/2022, 10/14/2022, and 10/19/2022, which indicated the nurse suctioned the patient, administered tube feedings and water flushes through the gastrostomy tube (a tube surgically inserted in the abdomen and into the stomach to deliver nutrition, hydration, and/or medication), and administered inhaled medications via nebulizer (a medical device that delivers medications through vapor for inhalation). Review of documents completed by LPN #1 and dated 11/9/2022, 11/10/2022, 11/11/2022, 11/12/2022, and 11/14/2022, indicated the LPN performed chest physiotherapty treatment (CPT, a technique to clear the airway by performing percussions to the chest wall to loosen up mucous). Review failed to evidence the plan of care included orders for the skilled nurse to suction, administer tube feedings and flushes, administer medications, and failed to evidence a physician order for the nurse to provide tracheostomy and gastrostomy care, perform CPT, and provide tracheostomy and gastrostomy care. Review of documents dated 10/12/2022, 10/13/2022, 10/14/2022, 10/19/2022, 10/24/2022, 10/25/2022, 10/26/2022, 10/27/2022, 10/30/2022, 10/31/2022, 11/1/2022, 11/2/2022, 11/4/2022, 11/5/2022, 11/7/2022, 11/9/2022, 11/10/2022, 11/11/2022, 11/14/2022, and 11/15/2022 electronically signed	G0724		

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G0724	Continued from page 68 by LPN #1 indicated the patient's temperature was 97.0 degrees Fahrenheit, pulse was 68 beats per minute, respirations were 16 breaths per minute, and blood pressure was 100/70. During an interview on 11/15/2022, at 2:10 PM, LPN #1 indicated she carried over the temperature, pulse, respiration, and blood pressure from previous visits rather than document the correct vital signs for the patient because she was having problems with the electronic medical record program. Review of an agency document titled "Supervisory Visit Note" completed by the clinical manager and dated 10/24/2022, indicated LPN #1 followed client's plan of care. Review failed to evidence the registered nurse provided LPN supervision to ensure the LPN followed the plan of care as directed. Review of an agency document titled "RN/LPN Skills Checklist" for LPN #1 signed by the clinical manager and dated 7/30/2019, failed to evidence the LPN was assessed for competency in providing CPT. During an interview on 11/16/2022, at 12:35 PM, the clinical manager indicated the LPN should have been assessed for competency for CPT. When queried why the RN assessed the LPN to provide care that followed the plan of care, the clinical manager remained silent.	G0724		
G0750	Home health aide services CFR(s): 484.80 Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure: all home health aide care plans were completed and individualized (See tag G0798); all home health aides followed the aide care plan (See tag G0800); and all home health aide supervisory visits conducted ensured the home health aide was following the aide care	G0750		

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G0750	Continued from page 69 plan (See tag G0818). The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the condition of participation 42 CFR 484.80 Home Health Aide Services.	G0750		
G0798	Home health aide assignments and duties CFR(s): 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). This STANDARD is NOT MET as evidenced by: Based on record review and interview, the registered nurse (RN) failed to ensure the home health aides had complete, patient-specific written patient care instructions to be performed by the home health aides in 3 of 4 clinical records reviewed with home health aide services. (#2, 5, 6) The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled “Home Health Aide Care Plan” stated, “… A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide [HHA], shall be developed by a Registered Nurse … The Home Health Aide Care Plan shall be reviewed and updated by the Registered Nurse minimally every sixty (60) days….” 2. Clinical record review on 11/14/2022, for Patient #2, start of care 7/17/2022, evidenced agency documents titled “Home Health Plan of Care [and] Certification”. Review of the plan of care for certification period 9/15/2022-11/13/2022 indicated the agency was to notify the physician of respirations less than 18 and greater than 29 breaths per minute. Review of the plan of care for certification period 11/14/2022-1/12/2023	G0798		

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G0798	Continued from page 70 indicated the agency was to provide home health aide services 7 days a week. Review of an agency document titled “Aide Plan of Care”, electronically signed by the administrator and dated 9/8/2022, evidenced the aide care plan was effective through 11/13/2022. Review indicated the HHA was to notify the case manager of respirations less than 15 and greater than 32 breaths per minute. Review failed to evidence the HHA care plan was accurate to reflect the orders in the medical plan of care. Review failed to evidence the HHA care plan was reviewed by the RN within 60 days as directed by the agency policy and failed to evidence an effective date beyond 11/13/2022. During an interview on 11/16/2022, at 11:13 AM, the administrator indicated the aide care plan was not reviewed yet and indicated there was not any other aide care plans beyond the effective date of 11/13/2022. The administrator indicated the respiration parameters in the HHA care plan should match the orders in the medical plan of care. 3. Clinical record review on 11/15/2022, for Patient #5, start of care 2/23/2013, evidenced agency documents titled “Aide Visit Note” dated 10/24/2022, 10/26/2022, 10/28/2022, 10/31/2022, 11/2/2022, 11/4/2022, 11/7/2022, 11/9/2022, 11/11/2022, and 11/14/2022, which indicated the home health aide obtained vital signs and assisted with bathing and activities of daily living (ADLs). Review failed to evidence the RN provided the home health aide with written, patient-specific instructions for care of the patient. 4. Clinical record review on 11/15/2022, for Patient #6, start of care 4/22/2013, evidenced agency documents titled “Aide Visit Note” dated 10/24/2022, 10/26/2022, 10/28/2022, 10/31/2022, 11/2/2022, 11/4/2022, 11/7/2022, 11/9/2022, 11/11/2022, and 11/14/2022, which indicated the home health aide obtained vital signs and assisted with bathing and ADLs. Review failed to evidence the RN provided the home health aide with written, patient-specific instructions for care of the patient. 5. During an interview on 11/17/2022, at 10:54 AM, the administrator indicated there should be a home health aide care plan for Patients #5 and #6.	G0798		

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G0798	Continued from page 71 410 IAC 17-14-1(m)	G0798		
G0800	Services provided by HH aide CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the home health aide provided services that were included in the plan of care in 3 of 4 clinical records reviewed receiving home health aide services. (#2, 4, 5) Findings include: 1. Record review evidenced an undated agency policy received 11/17/2022 titled, “Home Health Aide Care Plan” which stated “… the care plan will identify the duties to be performed such as personal care, ambulation, and exercise, household services … meal planning and preparation ….” 2. Record review evidenced an undated agency policy received 11/17/2022 titled, “Home Health Aide Services” which stated “… the aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising nurse … home health aide services will be documented in the client record ….” 3. Record review evidenced an undated agency policy received 11/17/2022 titled, “Home Health Aide: Documentation” which stated “… the home health aide shall utilize the appropriate home health aide flow sheet or charting form to document services rendered to the client ….” 4. Clinical record review for patient #4, start of care 07/16/2022, evidenced an agency document	G0800		

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G0800	Continued from page 72 effective date 09/08/2022 titled, “Aide Plan of Care” which indicated the home health aide was to provide hair care, foot care, nail care, sponge bath in AM and should be provided at each visit. Clinical record review evidenced agency documents titled, “Aide Note” dated 10/25/2022, 10/26/2022, 10/27/2022 and 10/28/2022 which failed to evidence hair care, nail care, foot care and sponge bath in AM was performed daily. Record review of agency document titled “Aide Note” dated 10/31/2022, 11/01/2022, 11/02/2022, 11/03/2022 and 11/04/22 failed to evidence the home health aide provided foot care, and nail care was performed daily. Record review of an agency document titled “Aide Note” dated 11/07/2022, 11/08/2022, 11/09/2022, 11/10/2022 and 11/11/2022 failed to evidence the home health aide provided foot care, nail care and sponge bath in AM was performed daily. Clinical record review 11/14/2022 evidenced an agency document titled, “Aide Plan of Care” which indicated prepare meals per prescribed diet. This document failed to indicate diet prescribed. During an interview on 11/16/2022, at 12:00 PM, the clinical supervisor indicated the aide should be following the plan of care and documenting care per aide plan of care orders. During an interview on 11/16/2022, at 12:00 PM, the clinical supervisor indicated the patient’s mother would tell the diet of the patient, but thinks she was on a regular diet. The clinical supervisor indicated the patient’s diet should be on the aide plan of care. 5. Clinical record review on 11/14/2022, for Patient #2, start of care 7/17/2022, evidenced an agency document titled “Aide Plan of Care” with an effective date of 9/8/2022, which indicated the home health aide was to obtain the patient’s pulse and respirations at every visit. Review indicated the home health aide should notify the case manager if the patient’s systolic blood pressure (the pressure against the arteries when the heart is contracting, represented by the top number) is greater than 160. Review indicated the home health aide should wash the patient’s hair weekly and should provide hair care and mouth care at every visit.	G0800		

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G0800	Continued from page 73 Review of agency documents titled “Aide Visit Note” dated 11/13/2022 and 11/14/2022 failed to evidence the home health aide obtained the patient’s respirations at the evening visit and failed to obtain the patient’s pulse at the morning visit. Review indicated the home health aide washed the patient’s hair on 11/6/2022, 11/7/2022, 11/8/2022, 11/9/2022, 11/10/2022, 11/11/2022, 11/12/2022, 11/13/2022, and 11/14/2022. Review failed to evidence the home health aide completed hair care and mouth care during the evening visit on 11/6/2022, 11/7/2022, 11/8/2022, 11/9/2022, 11/10/2022, 11/11/2022, and 11/12/2022 and failed to provide mouth care during the evening visit on 11/13/2022 and 11/14/2022. Review indicated the patient’s blood pressure was 168/83 at the evening visit on 11/13/2022 and failed to indicate the home health aide notified the case manager. During an interview on 11/16/2022, at 11:26 AM, the administrator indicated the home health aide should have obtained the pulse and respiration at every visit. 6. Clinical record review on 11/15/2022, for Patient #5, start of care 2/23/2013, evidenced agency documents titled “Aide Visit Note” dated 10/21/2022, 10/24/2022, 10/26/2022, 10/28/2022, 10/31/2022, 11/2/2022, 11/4/2022, 11/7/2022, 11/9/2022, 11/11/2022, and 11/14/2022. Review indicated the home health aide assisted the patient with personal care and activities of daily living (ADLs). Review failed to evidence a home health aide care plan and failed to evidence the home health aide provided services as directed by the aide care plan. During an interview on 11/17/2022, at 10:53 AM, the alternate administrator indicated the aide did whatever the patient needs. 7. Clinical record review on 11/15/2022, for Patient #6, start of care 4/22/2013, evidenced agency documents titled “Aide Visit Note” dated 10/21/2022, 10/24/2022, 10/26/2022, 10/28/2022, 10/31/2022, 11/2/2022, 11/4/2022, 11/7/2022, 11/9/2022, 11/11/2022, and 11/14/2022. Review indicated the home health aide assisted the patient with personal care and ADLs [activities of daily living]. Review failed to evidence a home health aide care plan and failed to evidence the home health aide provided services as directed by	G0800		

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G0800	Continued from page 74 the aide care plan. 8. During an interview on 11/16/2022, 11:28 AM, the administrator indicated the home health aide should follow the care plan.	G0800		
G0818	HH aide supervision elements CFR(s): 484.80(h)(4)(i-vi) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the home health aide (HHA) was supervised to ensure the aides furnished care that followed the patient's plan of care in 3 of 4 clinical records reviewed with home health aide services. (#2, 5, 6) The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled "Home Health Aide Supervision" stated, "… Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including but not limited to the following elements: … Following the client's plan of care for completion of tasks assigned to a home health aide …."	G0818		

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G0818	Continued from page 75 2. Clinical record review on 11/14/2022, for Patient #2, start of care 7/17/2022, evidenced an agency document titled “Aide Plan of Care” with an effective date of 9/8/2022, which indicated the home health aide was to obtain the patient’s pulse and respirations at every visit. Review indicated the home health aide should notify the case manager if the patient’s systolic blood pressure (the pressure against the arteries when the heart is contracting, represented by the top number) is greater than 160. Review indicated the home health aide should wash the patient’s hair weekly and should provide hair care and mouth care at every visit. Review of agency documents titled “Aide Visit Note” dated 11/13/2022 and 11/14/2022 failed to evidence the home health aide obtained the patient’s respirations at the evening visit and failed to obtain the patient’s pulse at the morning visit. Review indicated the home health aide washed the patient’s hair on 11/6/2022, 11/7/2022, 11/8/2022, 11/9/2022, 11/10/2022, 11/11/2022, 11/12/2022, 11/13/2022, and 11/14/2022. Review failed to evidence the home health aide completed hair care and mouth care during the evening visit on 11/6/2022, 11/7/2022, 11/8/2022, 11/9/2022, 11/10/2022, 11/11/2022, and 11/12/2022 and failed to provide mouth care during the evening visit on 11/13/2022 and 11/14/2022. Review indicated the patient’s blood pressure was 168/83 at the evening visit on 11/13/2022 and failed to indicate the home health aide notified the case manager. Review of an agency document titled “Supervisory Visit Note” completed by the clinical manager and dated 11/13/2022, indicated the aide provided services that followed the care plan. Review failed to evidence the registered nurse (RN) provided home health aide supervision to ensure the home health aides followed the aide care plan as directed. 3. Clinical record review on 11/15/2022, for Patient #5, start of care 2/23/2013, evidenced agency documents titled “Aide Visit Note” dated 10/21/2022, 10/24/2022, 10/26/2022, 10/28/2022, 10/31/2022, 11/2/2022, 11/4/2022, 11/7/2022, 11/9/2022, 11/11/2022, and 11/14/2022. Review indicated the home health aide assisted the patient with personal care and activities of daily living (ADL). Review failed to evidence a home	G0818		

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G0818	Continued from page 76 health aide care plan. Review of an agency document titled “Supervisory Visit Note” completed by the clinical manager and dated 10/28/2022, indicated the aide provided care that followed the care plan. Review failed to evidence the RN provided home health aide supervision to ensure the aide was providing services according to the care plan. 4. Clinical record review on 11/15/2022, for Patient #6, start of care 4/22/2013, evidenced agency documents titled “Aide Visit Note” dated 10/21/2022, 10/24/2022, 10/26/2022, 10/28/2022, 10/31/2022, 11/2/2022, 11/4/2022, 11/7/2022, 11/9/2022, 11/11/2022, and 11/14/2022. Review indicated the home health aide assisted the patient with personal care and activities of daily living (ADL). Review failed to evidence a home health aide care plan and failed to evidence the home health aide provided services as directed by the aide care plan. Review of an agency document titled “Supervisory Visit Note” completed by the clinical manager and dated 10/28/2022, indicated the aide provided care that followed the care plan. Review failed to evidence the RN provided home health aide supervision to ensure the aide was providing services according to the care plan. 5. During an interview on 11/17/2022, at 11:01 AM, the administrator indicated the aide supervisory visit note should not have been marked to indicate the aide was following the care plan. 410 IAC 17-14-1(n)	G0818		
G0940	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and	G0940		

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G0940	Continued from page 77 all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the organization and management of the home health agency as follows: the administrator failed to maintain the day to day operations of the agency (see tag G0948), the clinical manager failed to provide oversight of assuring patient needs were continually met (see tag G0966), and the clinical manager failed to assure the implementation of the plan of care (see tag G0968). The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.105 Organization and Administration of Services.	G0940		
G0948	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the administrator failed to be responsible for the day-to-day operations of the agency. The findings include: Review of an undated agency policy obtained 11/17/2022, titled “Administrative Control” stated, “... At a minimum, the Administrator ... must ... Manage the daily operations of the agency ....” The administrator failed to ensure the day-to-day operations of the home health agency as evidenced by: The administrator failed to ensure there was a complete Emergency Preparedness Program in place	G0948		

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G0948	Continued from page 78 for the home health agency. Please see tags associated with federal regulation 42CFR 484.102. The administrator failed to ensure OASIS (Outcome and Assessment Information Set, a comprehensive assessment data collection tool) assessments were transmitted to the CMS system. Please see tag G0370. The administrator failed to ensure the agency policy was followed for the review of medications. Please see tag G0536. The administrator failed to ensure all patients had a written plan of care which was reviewed and signed by a physician and failed to ensure all services provided followed the plan of care for agency patients. Please see tag G0572. The administrator failed to ensure the plan of care was individualized and included all required elements. Please see tag G0574. The administrator failed to ensure the primary care physician was promptly alerted to changes in the patient's condition. Please see tag G0590. The administrator failed to ensure there was coordination of care amongst all disciplines servicing the patients. Please see tag G0606. The administrator failed to ensure there was a Quality Assessment and Performance Improvement (QAPI) program maintained at the home health agency. Please see tag G0640. The administrator failed to ensure skilled professionals created clinical notes and/or accurate complete notes for all services provided to patients. Please see tag G0716. The administrator failed to ensure the skilled professional provided supervision of the licensed practical nurse (LPN). Please see tag G0726.	G0948		

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G0948	Continued from page 79 The administrator failed to ensure all home health aide care plans were complete and individualized. Please see tag G0798. The administrator failed to ensure all services were provided by the home health aide as directed in the aide care plan. Please see tag G0800. The administrator failed to ensure the supervising nurse ensured the home health aide followed the aide care plan. Please see tag G0818. The administrator failed to ensure all clinical notes were appropriately authenticated and corrections were made per agency policy. Please see tag G1024. The administrator failed to ensure clinical records were protected from loss and unauthorized use. Please see tag G1028. During an interview on 11/14/2022, at 2:07 PM, the alternate administrator indicated the agency did not have physician orders for Patients #5 and #6 and indicated the agency should have discharged the patients but did not. During an interview on 11/17/2022, at 11:02 AM, the alternate administrator indicated the agency was wrong to not have current plans of correction for Patients #5 and #6. 410 IAC 17-12-1(c)(1)	G0948		
G0966	Assure patient needs are continually assessed CFR(s): 484.105(c)(4) Assuring that patient needs are continually assessed, and This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the clinical manager failed to provide oversight over assuring the patient needs were continually assessed in 2	G0966		

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G0966	Continued from page 80 of 2 clinical records reviewed with skilled nursing services. (#1, #3) The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled “Clinical Manager” stated, “… The oversight provided by the clinical manager(s) include: … Assuring the client needs are continually assessed….” 2. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled “OASIS [Outcome and Assessment Information Set] Assessment Details” dated 10/24/2022, which indicated the patient had a gastrostomy (a surgically created hole in the abdomen and into the stomach to deliver nutrition, hydration, and/or medication) and a tracheostomy (a surgically created hole in the neck and into the windpipe to assist with breathing). Review failed to evidence the comprehensive assessment included an assessment of the gastrostomy and tracheostomy sites to include patency, color, drainage, and type and size of tracheostomy and gastrostomy tubes. Review of an agency document titled “OASIS Assessment Details” dated 10/24/2022, indicated the patient was admitted to the hospital on 10/14/2022, with a diagnosis of pneumonia. Review failed to evidence the agency updated the comprehensive assessment upon the patient’s return home from the hospitalization. During an interview on 11/17/2022, at 11:04 AM, the clinical manager indicated the patient was hospitalized and stated the agency “just went with the old assessment”. 3. Clinical record review on 11/15/2022, for Patient #3, start of care 8/30/2022, evidenced a document from Hospital A dated 10/29/22, titled, “ED [Emergency Department] to Hosp [Hospital]-Admission (Discharged)”, which indicated the patient was admitted for sepsis (the body’s extreme reaction to an infection) and was discharged with IV (intravenously, through the veins) antibiotics. Review failed to evidence the agency updated the comprehensive assessment upon the patient’s return home from the hospitalization. During an interview on 11/16/22, at 12:30 PM, the	G0966		

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G0966	Continued from page 81 clinical manager indicated she did not know who provided the IV antibiotic therapy. 4. During an interview on 11/17/2022, at 11:48 AM, the clinical manager indicated only Patient #1 had a gastrostomy.	G0966		
G0968	Assure implementation of plan of care CFR(s): 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the clinical manager failed to provide oversight over the development, implementation, and updates of the individualized plan of care in 2 of 2 clinical records reviewed without a current plan of care. (#5, 6) The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled “Clinical Manager” stated, “… The oversight provided by the clinical manager(s) include: … Assuring the development, implementation, and updates of the individualized plan of care….” 2. Clinical record review on 11/15/2022, for Patient #5, start of care 2/23/2013, failed to evidence a plan of care since certification period ended on 9/13/2020. 3. Clinical record review on 11/15/2022, for Patient #6, start of care 4/23/2013, failed to evidence a plan of care since certification period ended on 5/14/2020. 4. During an interview on 11/17/2022, at 11:05 AM, the clinical manger indicated the patients did not have plans of care because the patients did not have a physician. The clinical manager indicated there were no physician orders for the patients. 410 IAC 17-14-1(a)(1)	G0968		
G1024	Authentication CFR(s): 484.110(b)	G1024		

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G1024	Continued from page 82 Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the clinician failed to sign clinical notes in 4 of 6 clinical records reviewed (#1, 2, 5, 6) and failed to make changes in the clinical record per agency policy in 1 of 4 clinical records reviewed receiving home health aide services. (#2) The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled “Clinical Record Content/Medical Record Retention” stated, “… Any person who gives client care … must … sign the entry, complete with his or her title to authenticate an entry in the clinical record … In the event that an employee wishes to correct data, it shall be done as an amendment, without change to the original entry….” 2. Review of an undated agency policy obtained 11/17/2022, titled “Documentation of Changes to the Medical Record” stated, “… If it is necessary to make an addition to a previous entry, this must be done using an addendum to the record. The entry will be marked as an addendum and must include the date it is written and the visit date that the entry relates to….” 3. Clinical record review on 11/15/2022, for Patient #1, start of care 6/27/2022, evidenced an agency document titled “Supervisory Visit Note” completed by the clinical manager and dated 10/24/2022, which failed to evidence the signature of the clinical manager. During an interview on 11/17/2022, at 10:17 AM, the clinical manager indicated the document should be signed and dated. 4. Clinical record review on 11/14/2022, for Patient #2, start of care 7/17/2022, evidenced agency documents titled “Aide Visit Note” completed by home health aide #3 and dated	G1024		

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G1024	Continued from page 83 11/6/2022, 11/7/2022, 11/8/2022, 11/9/2022, 11/10/2022, 11/11/2022, 11/12/2022, 11/13/2022, and 11/14/2022, which failed to evidence a clinician's signature. Review on 11/14/2022, evidenced an electronic agency document titled "Aide Visit Note", completed by HHA #3 and dated 11/13/2022. Review indicated the patient's blood pressure was 168/83. Review of the electronic agency document on 11/16/2022, indicated the patient's blood pressure was now 128/83 for the HHA 11/13/2022, visit. Review failed to evidence corrected blood pressure was completed without changing the original document and corrected per the agency's policy. During an interview on 11/16/2022, at 11:35 AM, HHA #3 indicated she changed the blood pressure the previous day and did not make an amendment to the original document. During an interview at the entrance conference on 11/14/2022, at 10:31 AM, the alternate administrator indicated the agency had not had any issues with needing to make corrections in the clinical record and was unsure of the process clinicians should take if needing to make a correction. 5. Clinical record review on 11/15/2022, for Patient #5, start of care 2/23/2013, evidenced agency documents titled "Aide Visit Note" dated 10/24/2022, 10/26/2022, 10/28/2022, 10/31/2022, 11/2/2022, 11/4/2022, 11/7/2022, 11/9/2022, 11/11/2022, and 11/14/2022. Review failed to evidence the home health aide signed the visit notes. Review indicated the patient's pulse was 22 beats per minute on 10/24/2022, 26 beats per minute on 10/31/2022, and 32 beats per minute on 11/14/2022 and indicated the respirations were 74 breaths per minute on 10/24/2022, 76 breaths per minute on 10/31/2022, and 78 breaths per minute on 11/14/2022. 6. Clinical record review on 11/15/2022, for Patient #6, start of care 4/22/2013, evidenced agency documents titled "Aide Visit Note" dated 10/24/2022, 10/26/2022, 10/28/2022, 10/31/2022, 11/2/2022, 11/4/2022, 11/7/2022, 11/9/2022, 11/11/2022, and 11/14/2022. Review failed to evidence the home health aide signed the visit notes. Review indicated the patient's pulse was 26 beats per minute on 11/14/2022 and 11/16/2022 and indicated the respirations were 74 breaths per	G1024		

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G1024	Continued from page 84 minute on 11/14/2022 and 76 breaths per minute on 11/16/2022. 7. During an interview on 11/16/2022, at 11:28 AM, the alternate administrator indicated the agency has never insisted the staff sign their notes. 8. During an interview on 11/17/2022, at 11:03 AM, the administrator indicated the pulse and respirations were not documented correctly. 410 IAC 17-15-1(a)(7)	G1024		
G1028	Protection of records CFR(s): 484.110(d) Standard: Protection of records. The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164. This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the clinical records were protected to prevent loss and unauthorized use. The findings include: 1. Review of an undated agency policy obtained 11/17/2022, titled “Clinical Record Content/Medical Record Retention” stated, “… Clinical record information shall be safeguarded against loss or unauthorized use … Protected Health Information will be available only to those who must use it … The clinical records shall be stored in a secure area with ready access by authorized professional and clerical staff only … All open clinical records, when not in use, will be kept in a locked file in the agency office … Clinical records will be stored in a metal cabinet or equivalent to minimize the possibility of damage….” 2. During an interview on 11/14/2022, at 11:45 AM, the alternate administrator indicated Administrative Staff #4 was going to retrieve the active patient roster from the electronic medical	G1028		

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G1028	Continued from page 85 record. During an interview on 11/17/2022, at 11:54 AM, the alternate administrator indicated Administrative Staff #4 does not have access to the electronic medical record system and indicated Administrative Staff #4 used the alternate administrator's access to the electronic medical record to retrieve the patient list requested at survey entrance on 11/14/2022. 3. During an interview at entrance on 11/14/2022, at 10:31 AM, the alternate administrator indicated the agency used file slots located in the administrator's office to store documentation that came back signed from the physicians' offices. During an observation on 11/17/2022, at 10:32 AM, there were unsecured documents with the names and addresses of multiple patients covering the desk, chairs, floor, and filled in multiple open storage containers unattended in the alternate administrator's unlocked, open office. Documents were observed in an open slot filing box labeled with the name for Patients #1, #2, #3, #4, #5, and #6 in the administrator's office. Clinical records were not observed to be stored in a manner that protected the patient information from loss and unauthorized use. During an interview on 11/17/2022, at 10:32 AM, the alternate administrator indicated the papers located in the alternate administrator's office were old patient documents and billing information for patients. During an interview on 11/17/2022, at 10:41 AM, the administrator indicated she was unaware the agency's policy indicated the clinical records were to be stored in a metal cabinet. 410 IAC 17-15-1(c)	G1028		