STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157081	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACME HEALTH SERVICE INC	6302 N RUCKER RD STE J, INDIANAPOLIS, IN, 46220

(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 a Medicare participating non-deemed Home Health Agency. Dates of Survey: 02-07, 02-08, 02-09, and 02-12-2024 CCN: 157081 Census: 54 Unduplicated Skilled Admissions: 2 At this Emergency Preparedness survey, Acme Health Services Inc, was found to have been out of compliance with the requirements of Emergency Preparedness for Medicare and Medicaid participating	E0000		

	CFR 484.102. The cumulative effect of these systemic problems resulted in Acme Health Services Inc, being found to be out of compliance with the condition: 42 CFR 484.102. QR completed by Area 3 on 2/20/2024.			
E0001	Establishment of the Emergency Program (EP) 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §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	E0001	Theagency does have an Emergency Preparedness Program which involves both officestaff as well as front line team members. The last quarterly emergency preparedness review and activity by officeteam members occurred in October 2023; and the frontline team members have beenscheduled for an emergency preparedness tabletop activity on March 12, 2024. Agency does recognize that many of thedocuments in the Emergency Preparedness Binder, such as the local contactlisting and district map for District 5, were outdated and were revised duringthe survey process. The agency's plan ofcorrection has included,	2024-02-28

	provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: Based on record review and interview, the agency failed to ensure an Emergency Preparedness program was in place for 1 of 1 home health agency. Findings Include: 1. The agency provided a revised April 2017 ACHC Home Health policy titled "Emergency Management Plan", Policy No. 6-037.1. The policy indicated but was not limited to, "Purpose ... To establish a plan which will allow for continuation of services in the event of a disaster, natural or man-made, affecting the organization or		but has not been limited to, updating emergencycontact listings; updating internal emergency phone tree which is the pyramidphone communication plan; updating agency's Hazard Vulnerability AnalysisWorksheet, as well as hazard vulnerability planning priorities table; and updatingcommand structure. In addition to theseupdates, the agency has also updated emergency preparedness in-service andtraining materials which will be used for quarterly in-services andtrainings. To further ensure compliance,the agency has re-joined the Indiana District 5 Healthcare Coalition and hasappointed the agency's Human Resource Director as the agency point of contactfor coalition contact and communication. Additionally, the agency has entered into a memorandum of understandingwith another local home health provider which will serve as an agreement that willallow both agencies the ability to support and assist one another in the eventof an emergent event or disaster in our geographical service areas. The Human Resource Director will be	

	the community and to ensure the safe management of staff while securing patient and employee records ..." 2. During a review of the Emergency Preparedness binder, it evidenced an undated document titled "Hazard Vulnerability Analysis Worksheet". A document titled "Emergency Preparedness" dated 10-20-2023 evidenced the agency reviewed education regarding active shooter, tornado, flood, civil unrest, and emergency shelter. There was no evidence an active drill or tabletop exercise was ever completed. There was no evidence the agency's emergency preparedness plan was reviewed annually or as needed. 3. During an interview with the Executive Director on 02-12-2024 at 5:09 PM, they indicated they had no Emergency Preparedness program and were working on it. They indicated the date April 2017 on the Emergency Preparedness policy was most likely the last time the policy was reviewed and revised. They		responsiblefor ensuring that the content within the emergency preparedness binder is keptcurrent and up-to-date, and for further ensuring that quarterly in-services andannual tabletop activities are scheduled and held. This deficiency had the potential to affectall patients and the Administrator is responsible for ensuring that this planof correction is followed. The ExecutiveDirector and Administrator will review the emergency preparedness plan on amonthly basis to further monitor this plan of correction. This plan ofcorrection will remain ongoing in nature and compliance threshold is 100%.	

	performed a tabletop exercise and had not collaborated with local, state, and federal officials.			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification of a Home Health provider. Partially Extended survey on: 02-08-2024 at 12:50 PM Fully extended survey on: 02-09-2024 at 9:05 AM Survey Date: 02-07, 02-08, 02-09, and 02-12-2024 12-Month Unduplicated Skilled Admissions: 2 Active Census: 54 This deficiency report reflects State Findings cited in	G0000		

	Refer to the State Form for additional State Findings. During this Federal Recertification Survey, Acme Health Service Incorporated was found to be out of compliance with Conditions of Participation 484.102 Emergency Preparedness, 484.60 Care Planning, Coordination of Services, and Quality of Care; 484.65 Quality Assessment and Performance Improvement; and 484.105 Organization and Administration of Services. Based on the Condition-level deficiencies during the February12, 2024 survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on November 10, 2020. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning February 12,			

	2024, and continuing through February 11, 2026. QR completed by Area 3 on 2/20/2024.			
G0372	Encoding and transmitting OASIS 484.45(a) Standard: An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary. Based on record review and interview, the agency failed to submit OASIS (Outcome and Assessment Information Set) within 30 days of assessment completion for 2 of 2 qualified active skilled records reviewed where OASIS information was collected and transmitted. (Patients: #1, and 2) Findings Include: 1. An agency policy with a revision date of October 2016, titled "OASIS Data Transmission" indicated but was not limited to, " ... Policy: The	G0372	The agency has reviewed theinternal OASIS aging report and ensured that any outstanding OASIS informationhas been submitted into the IQIES portal. The former agency member who was responsible for OASIS submission is nolonger with the agency and since the date of survey, the Executive Director hasreceived additional training on OASIS and associated submissionrequirements. Presently, this deficientpractice had the potential to affect only two skilled patients. To ensure that this deficient practice doesnot again occur, the agency has established updated protocol which will requirethe agency's Executive Director to review the OASIS aging report on Friday ofeach week and to ensure that OASIS submission is transmitted via the IQUIESportal for any Friday date on which an OASIS appears on the aging report. The agency Administrator will monitor	2024-03-12

	OASIS data transmission requirements as outlined in the Medicare Conditions of Participation, Reporting of OASIS Information 42 CFR 484.20. Procedure: 1. The organization will encode and transmit completed OASIS data for each applicable patient within thirty (30) days of the M0090 date, date assessment completed ... " 2. A review of the OASIS Agency final validation reports during presurvey preparation, with a reporting period of 10-01-2023 through 02-02-2024, indicated 2 records of Patient #1 with a submission date of 10-17-2023. Record 1 indicated Reason for Assessment (RFA) 04 (a Recertification), with an M0090 date of 11-15-2022. The submission date is more than 30 days after the M0090 date on this record. Record 2 indicated an RFA of 04 (a Recertification), with an M0090 date of 01-12-2023. The submission date is more than 30 days after the M0009 date on this record. The OASIS Agency Final Validation reports failed to evidence records of Patient #2 and failed to evidence timely submission of		thisplan of correction by reviewing the aging OASIS report, along with any OASISvalidation reports for the last thirty (30) days, on the last calendar day of eachmonth. This plan of correction will remain ongoingin nature and the threshold for compliance is 100%.	

	Patient #1. 3. A review of 2 Oasis Agency final validation reports on 01-12-2024, provided by the Executive Director, Admin 2, with a submission date of 02-10-2024, indicated 2 submissions were completed for a total of 3 records processed. On 02-10-2024 at 11:27 AM, Patient #1 RFA 04 (a Recertification), with a M0090 date of 01-12-2024, was submitted. On 02-10-2024 at 11:13 AM, submission of Patient #2's RFA 04 (a Recertification), with an M0090 date of 11-29-2023. The submission date is more than 30 days after the M0090 date on this record. The second submission of Patient #2's RFA 04 (a Recertification), with an M0090 date of 01-29-2024. 4. A review of the active clinical record for Patient #1 was reviewed, with a start of care date of 11-17-2024. The OASIS initial certification assessment was to be submitted for transmission by 12-17-2024. The record failed to evidence that OASIS submission occurred within 30 days of completion.			

	5. A review of the active clinical record for Patient #2 was reviewed, with a start of care date of 07-08-2017. The record evidence a recertification of 12-04-2023 to 02-01-2024. The OASIS recertification dated 11-29-2023, failed to be submitted for transmission by 12-29-2023. The record failed to evidence the OASIS submission occurred within 30 days of completion. During an interview on 02-12-2024 at 1:00 PM, the Executive Director, Admin 2, indicated they submitted the OASIS into IQIES. Admin 2 confirmed the OASIS had been transmitted late for Patient #1 and 2.			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure the comprehensive assessments were complete and accurately reflected the patient's status, including health, psychosocial, and cognitive status	G0528	The agency has launched an extensive nurse training programin which nurses and leadership are meeting on a weekly basis so that nurses, includingClinical Manager and Alternate Clinical Manager, can be in-serviced andre-trained on the process of comprehensive assessments. Nurses are beingre-trained both individually and in group sessions, step-by-step through	2024-03-06

	in 4 of 6 active records reviewed (Patients: #1, 3, 4, and 5) and 5 of 6 and focused records reviewed. (Patients: #10 11, 12, 13, and 14) Findings Include: 1. An agency policy with a revision date of October 2016, titled "Initial and Comprehensive Assessment" indicated but was not limited to, " ...The assessment will be patient-specific and comprehensive to include the patient's needs for home care, rehabilitative care, social, and discharge planning needs ... Patient's functional status, including but not limited to ... The patient's psychosocial status ... cognitive limitations ... Equipment presently in the home... Any identified symptoms of pain ... Patient and family/caregiver support systems and the type of care the family/caregiver is available, capable, and willing to provide care ... " 2. An agency policy with a revision date of October 2016, titled "Ongoing Assessments" indicated but was not limited to, " ...The clinician will reassess the patient for: A. Blood pressure, pulse, respirations,		eachsection of the comprehensive assessment process, as related to agency policy "Initialand Comprehensive Assessment, Policy 4-018.1;" "Ongoing Assessments, Policy4-019.1;" and "Reassessment/Recertification, Policy 4-020.1". Thistraining includes, but is not limited to, re-assessing patient for bloodpressure, pulse, respiration, temperature, weight (when indicated), painstatus, breath sounds, skin integrity, bowel sounds, elimination, appetite anddiet, nutritional status, mental status, functional status, safety and homeenvironment, patient and family/caregiver support, progress towards goals andpatient needs and problems, compliance to treatment and/or medication, patientresponse to care and changes in patient condition. Training also includesappropriate documentation of all durable medical equipment, as well asdetermining the need for any additional durable medical equipment. Nursesare also being trained on the importance of discussing discharge planning with	

	temperature C. Pain status D. Breath sounds E. Skin integrity. F. Bowel sounds; elimination (urinary and bowel) G. Appetite/diet, nutritional status H. Mental status I. Functional Status J. Safety/home environment K. Patient and family/caregiver support L Progress towards goals and patient needs and problems M. Compliance to treatment and/or medications … Patient's response to care … Changes in patient condition … " 3. During a home visit at the residence of Patient #1 on 02-09-2024 at 7:00 AM, the patient was observed in bed with a wedge cushion propping the patient on their side. The specialized bed had cushions side against the frame on the bed. The Registered Nurse (RN) 1, a family member of Patient #1, was observed disconnecting Patient #1's gastrojejunostomy (GJ) tube (a surgically placed soft narrow tube that enters the stomach in the upper part of the abdomen that allows for the passage of liquid feedings, water, and medications to be provided) from the kangaroo feeding pump (a machine used to deliver hydration and		patientsupon each visit and documenting whether a patient's services will remainongoing or if discharge date and plan has been formulated. The initialtraining program has already begun and is scheduled to run six weeks. Upon completion of initial training program, Administrator and ExecutiveDirector will determine the second phase of the re-education and trainingprogram to ascertain if weekly trainings are still necessary, or if thefrequency of the trainings may be reduced. Patient care is the toppriority, and if nurse performance, through the review of newly performedassessments, indicates that deficiencies in this process still exist, asrelated to the comprehensive assessment process, trainings will continue weekly. Nurses will be held accountable to the standard that all sections of thecomprehensive assessment must be completed, and the Clinical Manager andAlternate Clinical Manager will be responsible for ensuring that appropriatequality assurance is completed within 48 hours on each new comprehensiveassessment	

	nutrition) and flushed with 30 milliliters (ml) of water. RN 1 indicated Patient #1's last seizure was in October 2023. RN 1 indicated Patient #1 has Diazepam (used to treat anxiety, muscle spasms, and seizures) oral and nasal liquid to use as needed for seizures. The patient also receives Baclofen (used to treat muscle spasms). RN 1 confirmed the Clinical Manager did not review seizure plans or question RN1 regarding the patient's last seizure during their visit. A review of the clinical record for Patient #1, start of care 11-17-2024, contained a recertification comprehensive assessment dated 01-12-2024, and electronically signed by the Clinical Manager. The comprehensive assessment indicated vital signs listed were a blood pressure of 118/74, but failed to list posture and activity, heart rate listed at 78 and location radial, but failed to list regular or irregular and posture, respiratory status indicated oxygen saturation level of 98% and lung sounds were absent, the nutritional status indicated regular diet, tube feeding 240 cubic		performed on a patient. Any deficiencies found by clinicalmanagement will be addressed with the assessing nurse who will be responsiblefor correcting said deficiencies within 24 hours and assessment re-submitted toclinical management for further review. Clinical management will beresponsible for ensuring that all assessments are free from deficiencies andwill report directly to the Administrator and Executive Director on this planof correction. This deficient practice had the potential to affect allpatients, and therefore, all patient assessments will be held to this standardand corrected during each patient's next scheduled re-certificationvisit. The agency continues to identify the patients who were referencedwithin the statement of deficiencies and is documenting such to ensure thateach of these deficient items are addressed during the next scheduledre-certification visit. RegardingPatient #1, as referenced in the statement of deficiencies, the ClinicalManager has met with the patient and RN #1 and a seizure management plan	

	centimeters (cc) frequency 3 times daily, pureed diet, thickened liquids, tube feeding continuous, gastrojejunostomy tube type, and size was left blank, neurological status indicated pupils were equal weakness of cerebral palsy (a condition marked by impaired muscle coordination and spasms), and neurological impairments indicated memory loss, but failed to address seizures. A review of the plan of care for the recertification period from 01-16-2024 to 03-15-2024, indicated but was not limited to diagnoses, Spastic quadriplegic cerebral palsy (a condition that affects the ability to control muscles and movement in all four limbs, the trunk, and face), Neuromuscular scoliosis (a sideways curvature of the spine), Localization-related (focal) (partial) symptomatic epilepsy (a condition caused by certain brain activity causing seizure activity). During an interview on 02-08-2024 at 10:38 AM, the Clinical Manager confirmed they did not review or complete a seizure plan for Patient #1. The Clinical Manager indicated they are to complete a head-to-toe assessment on every comprehensive		hasbeen formulated and implemented. The Clinical Manager will again bemeeting with patient and RN #1 during the week of 3/4/2024, to further review theplan of care for patient. Regarding Patient #5, as referenced in thestatement of deficiencies, RN #3 and another agency RN have met with patientand family and have provided training to patient, caregiver and family asrelated to risks for and signs of aspiration and/or choking. AttendingRN's also educated patient and family on importance of securing suction machineand have offered help in obtaining physician order and follow up training onsuch, should patient and family agree to obtain suction machine. TheClinical Manager has the ultimate responsibility to ensure that this plan ofcorrection is followed. To further ensure said correction, theAdministrator and Executive will perform additional quality assurance checks oncomprehensive assessments, to include no less than 10% of assessments performedmonthly. This plan of correction will remain ongoing in nature andcompliance threshold is 100%.	

G0530	Strengths, goals, and care preferences 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on record review and interview, the agency failed to ensure all patients received a comprehensive assessment reflecting their current strengths, patient-specific and measurable goals, and care preferences for 5 of 6 active clinical records reviewed (Patients #1, 3, 4, 5, and 6) and 5 of 6 active focused records reviewed (Patients #9, 10, 11, 13, and 14) Findings Include: 10. A review of the clinical record for Patient #1, start of care date of 11-17-2024, contained a plan of care for the recertification period from 01-16-2024 to 03-15-2024. The plan of care indicated but was not limited to diagnoses, Spastic quadriplegic cerebral palsy (a condition that affects the ability to control muscles and movement in all four limbs, the trunk, and face), Neuromuscular scoliosis (a	G0530	As noted above in G0528, theagency has launched an extensive nurse training program in which nurses andleadership are meeting on a weekly basis so that nurses, including ClinicalManager and Alternate Clinical Manager, can be in-serviced and re-trained onthe process of comprehensive assessments. Nurses are being re-trained bothindividually and in group sessions, step-by-step through each section of thecomprehensive assessment process. Thistraining includes, but is not limited to, those areas referenced in G0528, aswell as patient strengths, goals, care preferences. Training also addresses that all patientsmust have problems, interventions and goals identified and that said goals mustbe patient-specific and measurable. Training also includes re-educating nurses on the responsibility toprovide documentation in the comprehensive assessment when patient education occurs,and the areas related to said education. Training also includes honoring patient preferences, as related totiming of visits, as well as all other	2024-02-28

	spine), Localization-related (focal) (partial) symptomatic epilepsy (a condition caused by certain brain activity causing seizure activity). The record contained a recertification comprehensive assessment dated 01-12-2024, electronically signed by the Clinical Manager. The comprehensive assessment failed to contain patient-specific measurable goals, failed to include Patient #1's strengths, and failed to include care preferences. During an interview on 02-02024 at 7:10 AM, Registered Nurse (RN) 1, the family member of Patient #1 indicated Patient #1 does not like loud noises. RN 1 further indicated Patient #1 enjoys swimming in the hot tub, loves to be talked to, and likes to listen to music. 11. During an interview on 02-12-2024 at 1:50 PM, the Clinical Manager confirmed Patient #1's comprehensive assessment and plan of care did not contain strengths, goals, and care preferences. 12. A review of the clinical record for Patient #3, start of		preferences. The initial training program has alreadybegun and is scheduled to run six weeks. Upon completion of initial training program, Administrator and ExecutiveDirector will determine the second phase of the re-education and trainingprogram to ascertain if weekly trainings are still necessary, or if thefrequency of the trainings may be reduced. Patient care is the top priority, and if nurse performance, through thereview of newly performed assessments, indicates that deficiencies in thisprocess still exist, as related to the comprehensive assessment process, strengths,goals and care preferences, trainings will continue on a weekly basis. Nurses will be held accountable to thestandard that all sections of the comprehensive assessment must be completed,and the Clinical Manager and Alternate Clinical Manager will be responsible forensuring that appropriate quality assurance is completed within 48 hours oneach new comprehensive assessment performed on a patient. Any deficiencies found by clinical managementwill be addressed	

	care 04-05-2023, contained a plan of care for the recertification period from 01-03-2024 to 03-29-2024. The plan of care indicated but was not limited to diagnoses, Chronic kidney disease (the failure of the kidney to filter wastes and excess fluid from your blood), Dependence on supplemental oxygen, Diabetes mellitus with diabetic neuropathy (a condition caused by long-term elevated blood sugars causing nerve damage) and Anemia in chronic kidney disease (a condition where the red blood cell count is low due to impaired kidney function). The record contained a recertification comprehensive assessment dated 01-25-2024, signed by RN 3. The comprehensive assessment indicated in the section titled "Problems/Interventions/Goals" indicated the patient's stated goal was no hospitalizations or falls. The assessment failed to include the patient's strengths, measurable patient-specific goals, and care preferences. During an interview on 02-12-2024 at 4:47 PM, RN 3 indicated they could use a refresher in training. RN 3		with the assessing nurse who will be responsible forcorrecting said deficiencies within 24 hours and assessment re-submitted toclinical management for further review. Clinical management will be responsible for ensuring that allassessments are free from deficiencies and will report directly to theAdministrator and Executive Director on this plan of correction. This deficient practice had the potential toaffect all patients, and therefore, all patient assessments will be held tothis standard and corrected during each patient's next scheduledre-certification visit. The agencycontinues to identify the patients who were referenced within the statement ofdeficiencies and is documenting such to ensure that each of these deficientitems are addressed during the next scheduled re-certification visit. Additionally, agency Social Worker willreceive further training, and held to accountability, as it relates toreporting and documenting the clinical needs of patients with whom SocialWorker visits. Social Worker has	

	further indicated they were instructed they did not have to do goals and interventions. 13. A review of the clinical record for Patient #6, start of care 01-05-2024, contained a plan of care for the recertification period from 01-10-2024 to 03-09-2024. The plan of care indicated The plan of care indicated but was not limited to diagnoses, Chronic combined systolic (congestive) and diastolic heart failure (the heart's inability to pump blood to the rest of the body), Chronic atrial fibrillation (an irregular and often rapid heart rhythm that can lead to blood clots), Pain in the right knee, and Essential hypertension (high blood pressure). The record contained a recertification comprehensive assessment dated 01-15-2024, electronically signed by the Clinical Manager. The comprehensive assessment indicated in the section titled "Problems/Interventions/Goals" was left blank. The assessment failed to include the patient's strengths, patient-specific and measurable goals, and care preferences. During a home visit at Patient		beenre-educated on responsibility to ensure that all charting is completed within24 hours of patient contact and that all clinical needs are immediatelyreported to Clinical Director and/or Alternate Clinical Manager. The Administrator and Executive will monitorSocial Worker's charting on a weekly basis by reviewing the charting on no lessthan 10% of Social Worker's monthly visits. The Clinical Manager has theultimate responsibility to ensure that this plan of correction isfollowed. To further ensure saidcorrection, the Administrator and Executive will perform additional qualityassurance checks on comprehensive assessments, to include no less than 10% ofassessments performed, on a monthly basis. This plan of correction will remain ongoing in nature and compliancethreshold is 100%.	

	#6's residence on 02-12-2024 at 10:00 AM, Patient #6 indicated they had short-term memory. Patient #6 indicated they had difficulty remembering to take their medication and doing their eye drops, until the patient and the Medical Social Worker (MSW), came up with the plan to do it at prayer time. Patient #6 is Muslim and prays 5 times a day. The MSW confirmed agency staff visits must be scheduled around the patient's daily prayers. 14. A focused review of the clinical record of Patient #11, start of care 06-16-2023, contained an incomplete plan of care for the recertification from 02-11-2023 to 04-10-2024. The plan of care indicated but was not limited to diagnoses, Unspecified symptoms and signs involving functions following cerebral infarction (the effects of a stroke when the brain cells die when they do not get enough blood), Chronic diastolic (congestive) heart failure (the heart's inability to pump blood to the rest of the body) and Chronic atrial fibrillation ((an irregular and often rapid heart rhythm that can lead to blood			

clots). The record contained a recertification comprehensive assessment dated 02-07-2024, electronically signed by the Clinical Manager. The comprehensive assessment indicated in the section titled "Problems/Interventions/Goals" was left blank. The assessment failed to include the patient's strengths, patient-specific and measurable goals, and care preferences.

During an interview on 08-12-2024 at 12:45 PM, the Executive Director, Admin 2, and the Clinical Manager confirmed there were no goals, or care preferences listed on the plan of care for Patients #1, 3, 6, and 11.

1. A review of an ACHC Home Health policy revised October 2016 titled "Initial and Comprehensive Assessment" Policy No. 4-018.1 indicated but was not limited to, " ... 4. A. Patient problems/needs/strengths ... E. Baseline information to be used to measure the patient's progress toward achievement of desired outcomes ..."

2. A review of Patient #4's

	clinical record evidenced a plan of care with a start of care date of 02-18-2019 and a recertification date from 01-23-2024 to 03-22-2024 and indicated a primary diagnosis of Multiple Sclerosis (a disease of the brain and spinal cord affecting speech and movement), Idiopathic peripheral autonomic neuropathy (a disease causing damage to the nervous system, causing pain and weakness in the body), Hypertensive heart disease (chronic high blood pressure causing changes in the heart), Chronic diastolic heart failure (the main pumping chamber in the heart becomes stiff and fails to fill with blood properly), Hyponatremia (low sodium), Hypokalemia (low potassium), and Hyperlipidemia (high lipid levels, such as cholesterol). The clinical record evidenced a comprehensive assessment dated 01-18-2023, by Registered Nurse (RN) 3, and indicated the patient required assistance from the Home Health Aide (HHA) and Homemaker for assistance including, but not limited to, personal care, grooming, bathing, dressing, and mobility. The assessment included a			

	section titled "Problems/Interventions/Goals" and it evidenced the patient was to perform Instrumental Activities of Daily Living (IADLS) safely with assistance and indicated the goal was to be met by the first week of the start of the service. The goal was dated 09-21-2022. The agency failed to ensure the goal was patient-specific and measurable. A goal indicated the patient was to ambulate safely from the bedroom to the living room with their rollator/cane but failed to include when the goal was to be met. A goal indicated the activity tolerance was to be assessed. The agency failed to ensure the goal was patient-specific and measurable. The assessment failed to include seizure assessment and precaution goals. The comprehensive assessment failed to have patient-specific and measurable goals, the patient's strengths, and care preferences related to the patient's diagnoses. 3. A review of Patient #5's clinical record evidenced a plan of care, with a start of care date			

	recertification date from 12-22-2023 to 02-19-2024 and indicated a primary diagnosis of Quadriplegia (paralysis of all 4 limbs), Multiple Sclerosis (a disease of the brain and spinal cord affecting speech and movement), Ataxia (loss of muscle coordination), and Contracture of muscle). The clinical record evidenced a comprehensive assessment dated 12-18-2023, by the Clinical Manager (Admin) 3, and indicated the patient required assistance from a home health aide for assistance including, but not limited to, personal care, grooming, bathing, dressing, and mobility. A section titled "Problems/Interventions/Goals" evidenced the patient was to receive assistance with ADLs (Activities of Daily Living) 5 days a week and their satisfaction with the agency. The comprehensive assessment failed to evidence patient-specific, measurable, and pertinent goals related to the patient's diagnosis and need for home health aide (HHA) services, patient strengths, and any patient care preferences.			

	4. A review of Patient #9's clinical record evidenced a plan of care with a start of care date of 12-01-2018 and a recertification date from 01-04-2024 to 03-03-2024 and indicated a primary diagnosis of aftercare following joint replacement surgery, gait and mobility abnormalities, history of falling, Right artificial hip joint, pain in left hip, pain in right shoulder, Anemia (low level of red blood cells), Hypertension (high blood pressure), and a history of Transient Ischemic Attack (a brief interruption of blood to the brain). The clinical record included a comprehensive assessment dated 01-03-2024, by Admin 3, and indicated the patient required assistance from the HHA for assistance including but not limited to grooming, bathing, dressing, and mobility. A section titled "Problems/Interventions/Goals" evidenced the patient's goal was fall prevention through assessment and instruction with their mobility device. The goal failed to be patient-specific and measurable. A goal indicated the patient's needs were met safely but failed to evidence how the goal was to be			

	assessed. The assessment failed to include all necessary goals for a patient with a recent joint replacement, right artificial hip joint, pain in the left hip, and pain in the right shoulder. The assessment failed to include the patient's strengths, patient-specific and measurable goals, and care preferences. 5. A review of Patient #10's clinical record evidenced a plan of care with a start of care date of 06-09-2019 and a recertification date from 01-14-2024 to 03-13-2024 and evidenced diagnoses of Autistic disorder (a developmental disability), speech disturbances, and behavioral and emotional disorders. The clinical record evidenced a comprehensive assessment dated 01-10-2024, by Admin 3, and included a section titled "Problems/Interventions/Goals". The goals indicated the patient received safe care during the certification period. The goals failed to indicate how the patient was safe during the care provided by the agency. The goals failed to be patient-specific and measurable for a patient with a developmental disorder, speech			

	disturbances, and behavioral and emotional disorders. The assessment failed to include the patient's strengths, patient-specific and measurable goals, and care preferences. 6. A review of Patient #13's clinical record evidenced a plan of care with a start of care date of 10-12-2022 and a recertification date from 02-04-2024 to 04-03-2024 and evidenced the diagnoses Chronic kidney disease, stage 5, unilateral osteoarthritis in the right hip (a disease where tissue in the right hip joint breaks down over time), chronic pain, Hypertension (high blood pressure), muscle weakness, and Benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate, with frequent urination or a weak stream). The clinical record evidenced a comprehensive assessment dated 01-31-2024, by Admin 3, and evidenced a section titled "Problems/Interventions/Goals". The section evidenced a goal to assess and instruct on fall risks. The goal failed to be patient-specific and measurable. The assessment failed to include the patient's			

	strengths, patient-specific and measurable goals, and care preferences. 7. A review of Patient #14's clinical record evidenced a comprehensive assessment dated 12-30-2023, by Registered Nurse (RN) 3, and it failed to evidence a list of the patient's diagnoses. The assessment failed to include the patient's strengths, patient-specific and measurable goals, and care preferences. 8. During an interview with Admin 3 on 02-12-2024 at 3:35 PM, they indicated the comprehensive assessment was to include the patient's individualized goals and care preferences. 9. During an interview with Registered Nurse (RN) 3 on 02-12-2024 at 4:45 PM, they indicated they included the patient's goals and any education needed in the comprehensive assessment.			
G0534	Patient's needs 484.55(c)(4)	G0534	As noted above in G0528 andG0530, the agency has launched an extensive nurse training program in whichnurses	2024-02-28

	The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review and interview, the agency failed to ensure a complete and accurate assessment of the patient's medical nursing, rehabilitative, social, and discharge planning needs in 5 of 6 active records reviewed (Patients: #1, 3, 4, 5, and 6) and 5 of 6 focused records reviewed. (Patients: #9, 10, 11, 13, and 14) Findings Include: 1. An agency policy with a revision date of October 2016, titled "Initial and Comprehensive Assessment" indicated but was not limited to, " ...The assessment will be patient-specific and comprehensive to include the patient's needs for home care, rehabilitative care, social, and discharge planning needs ... Patient's functional status, including but not limited to ... The patient's psychosocial status ... cognitive limitations ... " 2. An agency policy with a revision date of October 2016, titled "Discharge Planning" indicated but was not limited to, " ... Discharge planning will be initiated for every patient upon admission ... The		and leadership are meeting on a weekly basis so that nurses, includingClinical Manager and Alternate Clinical Manager, can be in-serviced andre-trained on the process of comprehensive assessments. Nurses are beingre-trained both individually and in group sessions, step-by-step through eachsection of the comprehensive assessment process. This training includes, but is not limitedto, those areas referenced in G0528 and G0530, as well as patient's medical,nursing, rehabilitative, social and discharge planning needs. Training includes that continuing care needsas well as discharge planning must be addressed at each patient visit. Nurseshave been re-educated that patients who receive continuous services, such asattendant care paid for by Medicaid Waiver, must still receive education ondischarge planning, even if discharge is not considered as a viable option inthe foreseeable future. Training alsoincludes a focus on addressing the psycho-social needs of patients who arealert and oriented but cannot verbally express their needs or desires, alongwith addressing	

	patient's continuing care needs will be assessed on an ongoing basis ... " 3. A review of the clinical record for Patient #1, start of care date of 11-17-2024, contained a plan of care for the recertification period from 01-16-2024 to 03-15-2024. The plan of care indicated but was not limited to diagnoses, Spastic quadriplegic cerebral palsy (a condition that affects the ability to control muscles and movement in all four limbs, the trunk, and face), Neuromuscular scoliosis (a sideways curvature of the spine), Localization-related (focal) (partial) symptomatic epilepsy (a condition caused by certain brain activity causing seizure activity). The record contained a recertification comprehensive assessment dated 01-12-2024, electronically signed by the Clinical Manager. The comprehensive assessment failed to contain patient-specific interventions related to the patient's diagnosis of cerebral palsy, and epilepsy. The comprehensive assessment indicated in the section titled "Problems/Interventions/Goals" was left blank. The section titled "Discharge Plan" indicated when		the social needs of patients who are homebound. The initial training program has alreadybegun and is scheduled to run six weeks. Upon completion of initial training program, Administrator and ExecutiveDirector will determine the second phase of the re-education and trainingprogram to ascertain if weekly trainings are still necessary, or if thefrequency of the trainings may be reduced. Patient care is the top priority, and if nurse performance, through thereview of newly performed assessments, indicates that deficiencies in thisprocess still exist, as related to the comprehensive assessment process,trainings will continue on a weekly basis. Nurses will be held accountable to the standard that all sections of thecomprehensive assessment must be completed, and the Clinical Manager andAlternate Clinical Manager will be responsible for ensuring that appropriatequality assurance is completed within 48 hours on each new comprehensiveassessment performed on a patient. Anydeficiencies found by clinical management will be	

	services are no longer authorized by the payer. The assessment failed to include patient-specific interventions, social, rehabilitative, and discharge planning needs. During an interview on 02-09-2024 at 7:10 AM, Registered Nurse (RN) 1, a family member of Patient #1, indicated the Clinical Manager did not review the plan of care with RN 1. 4. A review of the clinical record for Patient #3, start of care 04-05-2023, contained a plan of care for the recertification period from 01-03-2024 to 03-29-2024. The plan of care indicated but was not limited to diagnoses, Chronic kidney disease (the failure of the kidney to filter wastes and excess fluid from your blood), Dependence on supplemental oxygen, Diabetes mellitus with diabetic neuropathy (a condition caused by long-term elevated blood sugars causing nerve damage) and Anemia in chronic kidney disease (a condition where the red blood cell count is low due to impaired kidney function). The record contained a		addressed with the assessingnurse who will be responsible for correcting said deficiencies within 24 hoursand assessment re-submitted to clinical management for further review. Clinical management will be responsible forensuring that all assessments are free from deficiencies and will reportdirectly to the Administrator and Executive Director on this plan ofcorrection. This deficient practice hadthe potential to affect all patients, and therefore, all patient assessmentswill be held to this standard and corrected during each patient's nextscheduled re-certification visit. Theagency continues to identify the patients who were referenced within thestatement of deficiencies and is documenting such to ensure that each of thesedeficient items are addressed during the next scheduled re-certificationvisit. The Clinical Manager has theultimate responsibility to ensure that this plan of correction isfollowed. To further ensure saidcorrection, the Administrator and Executive will perform additional	

	recertification comprehensive assessment dated 01-25-2024, signed by RN 3. The comprehensive assessment indicated in the section titled "Problems/Interventions/Goals" indicated the patient's stated goal was no hospitalizations or falls. The assessment failed to include patient-specific interventions, social, rehabilitative, and discharge planning needs. During an interview on 02-12-2024 at 4:47 PM, RN 3 indicated they could use a refresher in training. RN 3 further indicated they were instructed they did not have to do goals interventions, and discharge planning. 5. A review of the clinical record for Patient #6, start of care 01-05-2024, contained a plan of care for the recertification period from 01-10-2024 to 03-09-2024. The plan of care indicated but was not limited to diagnoses, Chronic combined systolic (congestive) and diastolic heart failure (the heart's inability to pump blood to the rest of the body), Chronic atrial fibrillation (an irregular		qualityassurance checks on comprehensive assessments, to include no less than 10% ofassessments performed, on a monthly basis. This plan of correction will remain ongoing in nature and compliancethreshold is 100%.	

	that can lead to blood clots), Pain in the right knee, and Essential hypertension (high blood pressure). The record contained a recertification comprehensive assessment dated 01-15-2024, electronically signed by the Clinical Manager. The comprehensive assessment indicated in the section titled "Problems/Interventions/Goals" was left blank. The section titled "Discharge Plan" indicated when services are no longer authorized by the payer. The assessment failed to include patient-specific interventions, social, rehabilitative, and discharge planning needs. During an interview on 02-12-2024 at 1:16 PM, when queried where to find interventions and goals in the clinical records, the Clinical Manager indicated they were unsure. 6. A focused review of the clinical record of Patient #11, start of care 06-16-2023, contained an incomplete plan of care for the recertification from 02-11-2023 to 04-10-2024. The plan of care indicated but was not limited to diagnoses, Unspecified			

	symptoms and signs involving functions following cerebral infarction (the effects of a stroke when the brain cells die when they do not get enough blood), Chronic diastolic (congestive) heart failure (the heart's inability to pump blood to the rest of the body) and Chronic atrial fibrillation ((an irregular and often rapid heart rhythm that can lead to blood clots). The record contained a recertification comprehensive assessment dated 02-07-2024, electronically signed by the Clinical Manager. The comprehensive assessment indicated in the section titled "Problems/Interventions/Goals" was left blank. The section titled "Discharge Plan" indicated Not Applicable (NA). The assessment failed to include e patient-specific interventions, social, rehabilitative, and discharge planning needs. During an interview on 02-09-2024 at 1:13 PM, RN 3 indicated they were unsure where to put interventions and that they needed more training. 7. On 02-12-2024 from 5:25 PM to 6:08 PM, the findings were reviewed with the			

	Administrator, Admin 2, and the Clinical Manager, which they had no further information or documentation to provide. A review of Patient #4's clinical record evidenced a plan of care with a start of care date of 02-18-2019 and a recertification date from 01-23-2024 to 03-22-2024 and indicated a primary diagnosis of Multiple Sclerosis (a disease of the brain and spinal cord affecting speech and movement), Idiopathic peripheral autonomic neuropathy (a disease causing damage to the nervous system, causing pain and weakness in the body), Hypertensive heart disease (chronic high blood pressure causing changes in the heart), Chronic diastolic heart failure (the main pumping chamber in the heart becomes stiff and fails to fill with blood properly), Hyponatremia (low sodium), Hypokalemia (low potassium), and Hyperlipidemia (high lipid levels, such as cholesterol). The clinical record evidenced a comprehensive assessment dated 01-18-2023, by Registered Nurse (RN) 3, and it failed to evidence the patient's rehabilitative needs, treatments, or goals related to			

	the patient's diagnoses of Multiple Sclerosis, Hypertensive heart disease, Chronic diastolic heart failure, Hyponatremia, Hypokalemia, and Hyperlipidemia. The comprehensive assessment failed to evidence the patient's social planning needs, for a patient who was homebound with mobility issues. The assessment indicated "NA- Not Applicable" for the patient's discharge planning needs. The agency failed to ensure the patient's discharge planning needs were included in the comprehensive assessment. A review of Patient #5's clinical record evidenced a plan of care, with a start of care date of 11-13-2019 and a recertification date from 12-22-2023 to 02-19-2024 and indicated a primary diagnosis of Quadriplegia (paralysis of all 4 limbs), Multiple Sclerosis (a disease of the brain and spinal cord affecting speech and movement), Ataxia (loss of muscle coordination), and Contracture of muscle). The plan of care, dated 12-18-2023 by the Clinical Manager (Admin) 3, evidenced a section titled "60			

	the patient had increased difficulty and pain when swallowing food and constipation. The clinical record evidenced a comprehensive assessment dated 12-18-2023 by Clinical Manager (Admin) 3 and it failed to evidence the patient's medical needs were addressed to reduce the increased difficulty and pain with swallowing. The assessment failed to evidence the patient's rehabilitative needs, treatments, or goals related to the patient's diagnoses of Multiple Sclerosis and Quadriplegia. The comprehensive assessment failed to ensure the patient's social planning needs were assessed for an alert and oriented individual, who had difficulty communicating their needs verbally, as evidenced in the assessment. A review of Patient #9's clinical record evidenced a plan of care with a start of care date of 12-01-2018 and a recertification date from 01-04-2024 to 03-03-2024 and indicated a primary diagnosis of aftercare following joint replacement surgery, gait and mobility			

	Right artificial hip joint, pain in left hip, pain in right shoulder, Anemia (low level of red blood cells), Hypertension (high blood pressure), and a history of Transient Ischemic Attack (a brief interruption of blood to the brain). The clinical record included a comprehensive assessment dated 01-03-2024, by Admin 3, and it failed to evidence the patient's rehabilitative needs, treatments, or goals related to the patient's diagnoses of a recent joint replacement, right artificial hip joint, pain in the left hip, and pain in the right shoulder. The comprehensive assessment failed to evidence the patient's social planning needs, for a patient who was homebound with mobility issues. A review of Patient #10's clinical record evidenced a plan of care with a start of care date of 06-09-2019 and a recertification date from 01-14-2024 to 03-13-2024 and evidenced diagnoses of Autistic disorder (a developmental disability), speech disturbances, and behavioral and emotional disorders. The clinical record evidenced a comprehensive assessment dated 01-10-2024,			

	by Admin 3, and it failed to evidence the patient's rehabilitative needs, treatments, or goals related to the patient's diagnoses for an Autistic disorder, speech disturbances, and behavioral and emotional disorders. The comprehensive assessment failed to evidence the patient's social planning needs, for a patient who was homebound with mobility and developmental issues. The assessment evidenced in the sub-section titled "Discharge planning needs identified: Yes …" The agency failed to ensure the patient's discharge planning needs were included in the comprehensive assessment. A review of Patient #13's clinical record evidenced a plan of care with a start of care date of 10-12-2022 and a recertification date from 02-04-2024 to 04-03-2024 and evidenced the diagnoses Chronic kidney disease, stage 5, unilateral osteoarthritis in the right hip (a disease where tissue in the right hip joint breaks down over time), chronic pain, Hypertension (high blood pressure), muscle weakness, and Benign prostatic hyperplasia			

	symptoms (enlarged prostate, with frequent urination or a weak stream). The clinical record evidenced a comprehensive assessment dated 01-31-2024, by Admin 3, and it failed to evidence the patient's rehabilitative needs, treatments, or goals related to the patient's diagnoses. The comprehensive assessment failed to evidence the patient's social planning needs. A review of Patient #14's clinical record evidenced a comprehensive assessment dated 12-30-2023, by Registered Nurse (RN) 3, and it failed to evidence a list of the patient's diagnoses. The assessment failed to have the patient's medical, rehabilitation, social, and discharge planning needs. During an interview with Admin 3 on 02-12-2024 at 3:35 PM, they indicated the comprehensive assessment was to include medical, rehabilitation, social, and discharge planning individualized to the patient. During an interview with RN 3 on 02-12-2024 at 4:45 PM, they			

	indicated they included discharge planning in the comprehensive assessment. 410 IAC 17-14-1(a)(1)(B)			
G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on record review and interview, the agency failed to ensure the patient's caregivers along with their frequency and willingness to assist in care were included in the comprehensive assessment for 3 of 6 (Patients: #1, 2, and 5) active clinical records reviewed and 1 of 6 (Patients: #10) active focused records reviewed. Findings Include: 4. A review of the clinical record for Patient #1 start of care 11-17-2024, contained a recertification comprehensive assessment dated 01-12-2024, and electronically signed by the Clinical Manager. The section Primary Caregiver indicated RN 1 the family member of Patient	G0538	Agency leadership has re-educatednurses, to include the Clinical Manager and the Alternate Clinical Manager, ontheir responsibility to ensure that the comprehensive assessment for eachpatient includes any primary caregivers who are willing, able and available toprovide care to a patient. In caseswhere patient has no primary caregiver who is willing, able and available,nurses have been re-educated to denote on the comprehensive assessment that noprimary caregivers are available. TheClinical Manager and Alternate Clinical Manager have the ultimateresponsibility of performing quality assurance on each patient undergoing astart of care, resumption of care or re-certification to ensure that thecomprehensive assessment meets this requirement. This deficient practice has the potential toaffect all patients and the Administrator and Executive	2024-02-28

	#1, was willing, available, and lives with Patient #1. The comprehensive assessment failed to include the scheduled availability. During an interview on 02-09-2024 at 7:10 AM, RN 1, the family member of Patient #1, indicated they have a full-time job for another company. 5. A review of the clinical record for Patient #2, start of care 07-08-2017, contained a recertification comprehensive assessment dated 01-27-2024, electronically signed by RN 2. The comprehensive assessment indicated Person 2, the family member of Patient #2, was Patient 2's mother and guardian. The section Primary Caregiver indicated no caregiver available. The comprehensive assessment indicated Patient #2 had a cognitive impairment, was physically disabled, and totally dependent on care to the diagnosis of Cerebral palsy (a condition that affects the ability to control muscles and movement. The comprehensive assessment failed to include the patient's primary caregiver, willingness and ability to		Director will conductadditional quality assurance reviews of assessments, at least quarterly, toensure that this plan of correction is being followed and this plan ofcorrection will remain ongoing in nature and the threshold for compliance is100%.	

	provide care, and availability and schedule. During an interview on 02-12-2024 at 1:30 PM, the Clinical Manager indicated they called Patient #2's home and spoke to Person 2, the family member of Patient #2. Peron 2 had taken Patient #2 to the emergency room, at Entity 24, an acute care facility for treatment for COVID-19. 1. A review of an ACHC Home Health policy revised October 2016 titled "Initial and Comprehensive Assessment" Policy No. 4-018.1 indicated but was not limited to, " ... C. O. Patient and family/caregiver support systems and the type of care the family/caregiver is available, capable, and willing to provide ..." A review of Patient #5's clinical record evidenced a plan of care, with a start of care date of 11-13-2019 and a recertification date from 12-22-2023 to 02-19-2024 and indicated a primary diagnosis of Quadriplegia (paralysis of all 4 limbs), Multiple Sclerosis (a disease of the brain and spinal			

	movement), Ataxia (loss of muscle coordination), and Contracture of muscle). The clinical record evidenced a comprehensive assessment dated 12-18-2023, by Clinical Manager (Admin) 3, and indicated the patient's primary caregiver was Person 20, Patient #5's relative. The comprehensive assessment evidenced Person 20 lived with the patient, but the assessment failed to evidence the relative's willingness and availability to provide care for the patient. The patient was fully dependent on another individual providing care for them as evidenced by their diagnoses of Quadriplegia and Multiple Sclerosis. A review of Patient #10's clinical record evidenced a plan of care with a start of care date of 06-09-2019 and a recertification date from 01-14-2024 to 03-13-2024 and evidenced diagnoses of Autistic disorder (a developmental disability), speech disturbances, and behavioral and emotional disorders. The clinical record evidenced a comprehensive assessment dated 01-10-2024, by Admin 3, and indicated the patient's primary caregiver was			

	Person 19, Patient #10's relative. The comprehensive assessment evidenced Person 19 lived with the patient, but the assessment failed to evidence the relative's willingness and availability to provide care for the patient. The patient was fully dependent on another individual providing care for them as evidenced by their diagnosis of Autistic disorder. During an interview with Admin 3 on 02-12-2024 at 3:35 PM, they indicated the comprehensive assessment was to include who the patient lived with and if the individual was willing and able to provide care for the patient.			
G0550	At discharge 484.55(d)(3) At discharge. Based on record review and interview, the agency failed to ensure the Registered Nurse (RN) completed a comprehensive discharge assessment on 1 of 2 discharge records reviewed. (Patient: #7) Findings Include:	G0550	Upon notification of thisdeficiency, the Clinical Manager finalized discharge assessment for Patient #7and notified physician of discharge. Agency leadership has audited all discharges dating back to 2/1/2023 todetermine if other deficiencies existed in this area. All identified deficiencies have beencorrected and relevant physicians notified. Agency leadership has re-educated nurses on the requirement to	2024-03-04

	1. An agency policy with a revision date of October 2016, titled “Discharge Criteria and Process” indicated but was not limited to, “ … The clinician will update the comprehensive … All discharge paperwork will be due in the office within 72 hours of the discharge date. This will include the discharge order, discharge summary, medication profile, and OASIS … ” 2. A review of the inactive clinical record for Patient #7, on 02-08-2024, with a discharge date of 10-20-2023, failed to contain a discharge comprehensive assessment, discharge order, and discharge summary. 3. On 02-08-2024 at 2:58 PM, requested the discharge assessment, orders, and summary for Patient #7. During an interview on 02-09-2024 at 4:00 PM, with the Intake/Medical Records Coordinator, Admin 6, when queried regarding the discharge records requested for Patient #7, indicated the record did not contain a discharge comprehensive assessment,		followagency policy as related to the discharge of patients. Nurses have been re-educated that comprehensivedischarge assessment must be completed and all associated paperwork to theagency within 72 hours from discharge. Leadership has further educated Clinical Manager and Alternate ClinicalManager of his/her responsibility to review said discharge documentation andperform quality assurance to ensure that it is completed timely within theelectronic health record. ClinicalManager and Alternate Clinical Manager have been re-educated and trained ontheir responsibility to ensure that all pertinent documents, discharge summary,assessment and medication list are sent to the relevant physician(s) and otherappropriate multi-disciplinary members. To ensure that this deficient practice does not again occur, theClinical Manager and/or Alternate Clinical Manager will provide updates duringdaily leadership meetings and quality improvement meetings. The Administrator and Executive Director willperform monthly audits, of no less than 50% of	

	discharge order, or discharge summary. 4. On 02-12-2024 at 9:02 AM, Admin 6, provided 2 agency documents dated 10-20-2023, titled "Discharge Assessment." One of the discharge assessments dated 10-20-2023, indicated the assessment status was incomplete and waiting on a signature. The second discharge assessment dated 10-20-2023, was electronically signed by the Clinical Manager and dated 10-25-2025, indicated it was incomplete waiting on QA(Quality Assurance) review. During an interview on 02-12-2024 at 9:02 AM, the Clinical Manager indicated they were completing the discharge assessment, summary, and order. 5. A review of agency documents, an agency letter dated 02-12-2024, and a fax confirmation, addressed to Patient #7's physician. The letter indicated the agency discovered during a chart audit they had not notified the physician of Patient #7's discharge and were		patient discharge records, toensure that nurses and nurse leadership are following this plan of correction. The threshold for compliance is 100% and thisplan of correction will remain ongoing in nature.	

	documents today. 6. On 02-12-2024 from 5:25 PM to 6:08 PM, the findings were reviewed with the Administrator, Admin 2, and the Clinical Manager, which they had no further information or documentation to provide.			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interview, the agency failed to ensure they accepted patients needing therapy on the reasonable expectation that they were able to meet the patient's therapy needs (See	G0570	The agency has launched anextensive nurse training program in which nurses and leadership are meeting ona weekly basis so that nurses, including Clinical Manager and AlternateClinical Manager, can be in-serviced and re-trained on the process ofcomprehensive assessments. Nurses are being re-trained both individually and ingroup sessions, step-by-step through each section of the comprehensiveassessment process as previously noted in prior deficiency responses, as wellas the through the care planning, coordination of services and quality of careprocesses. This training includes, butis not limited to, meeting the needs of therapy patients and notifying relevantphysicians of such, ensuring patient-specific and measurable outcomes and	2024-02-28

	G570); the agency failed to ensure services were provided per the plan of care and failed to ensure each patient received an individualized plan of care that identified patient-specific and measurable outcomes and goals that was periodically reviewed and signed by a physician (see G572); failed to ensure all Durable Medical Equipment (DME) and Supplies, specific frequency and duration of visits and treatments, all safety measures to protect against injury, patient specific interventions, measurable outcomes and goals identified by the home health agency and patient (see G574); failed to alert the physician of changes in a patient's condition (see G590); failed to coordinate care among all agency members that cared for patients (see G606); and failed to ensure they coordinated care delivery with other agencies providing care to ensure they meet the patient's needs (see G608). These practices affected 6 of 6 active clinical records reviewed, (Patients: #1, 2, 3, 4, 5, and 6) and 6 of 6 focused audits of active clinical records reviewed, (Patients: #9, 10, 11, 12, 13, and 14)		goals, ensuring appropriate DME anddocumentation of such, appropriately documenting specific frequency andduration of visits and treatments, safety measures to protect against injury,patient specific interventions, reporting significant changes to relevantphysicians and coordinating care among other agencies to ensure patient needsare met. The initial training programhas already begun and is scheduled to run six weeks. Upon completion of initial training program,Administrator and Executive Director will determine the second phase of there-education and training program to ascertain if weekly trainings are stillnecessary, or if the frequency of the trainings may be reduced. Patient care is the top priority, and ifnurse performance, through the review of newly performed assessments, plans ofcare and nurse documentation, indicates that deficiencies in this process stillexist, as related to the comprehensive assessment, care planning coordinationof care and quality of care processes, trainings will continue on a weeklybasis. Nurses will be held accountableto the standard that all sections of the	

G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure services were provided per the plan of care and failed to ensure each patient received an individualized plan of care, identified patient-specific measurable outcomes and goals for 5 of 6 active records reviewed (Patients: #1, 3, 4, 5, and 6) and 2 of 6 focused records reviewed (Patients: #11, and 14) Findings Include: 1. An agency policy with a revision date of October 2016, titled “Care Planning Process” indicated but was not limited to, “Purpose: To provide clinical direction to the clinicians providing patient care … A	G0572	The agency has launched anextensive nurse training program in which nurses and leadership are meeting ona weekly basis so that nurses, including Clinical Manager and AlternateClinical Manager, can be in-serviced and re-trained on the process ofcomprehensive assessments. Nurses are being re-trained both individually and ingroup sessions, step-by-step through each section of the comprehensiveassessment process as previously noted in prior deficiency responses G0570,G0534, G0530 and G0528. The comprehensiveassessment drives the plan of care process and flows through to the plan ofcare document within the electronic health record. During training, nurses are being re-educatedon the flow of this process and how an area of deficiency within thecomprehensive assessment will also result in deficiency within the plan ofcare. Regarding nurse training andre-education as related to the plans of care, they are being re-trained onitems to include, but not be limited to,	2024-02-28

	written plan of care will be initiated within five (5) days of start of care and updated at least every 60 days or as patient's condition warrants … The patient and family/caregiver will participate in decisions regarding the plan of care … The care planning process will be documented on the plan of care, individualized discipline-specific care plans … The plan of care includes: … G. Goals/outcomes to be achieved … " 2. A review of the clinical record for Patient #1 contained a recertification comprehensive assessment dated 01-12-2024, and electronically signed by the Clinical Manager. The comprehensive reassessment failed to contain patient-specific goals, address progress towards any goals, and discharge plans when services are no longer authorized by the payer. A review of the plan of care for the recertification period from 01-16-2024 to 0-15-2024, The plan of care indicated but was not limited to diagnoses, Spastic quadriplegic cerebral palsy (a condition that affects the ability to control muscles		identifying patient-specific measurableoutcomes and goals and reporting such to relevant physician, addressingprogress towards any goals, discussing and documenting discharge planning,providing clinical direction to caregivers and clinicians providing care,ensuring plan of care is initiated within five (5) days of the patient start ofcare, ensuring that plan of care is updated at least every sixty (60) days oras patient condition warrants, meeting the needs of therapy patients andnotifying relevant physicians of such, ensuring patient-specific and measurable outcomes and goals, ensuringpatient preferences are documented, completing appropriate attendant careand/or home health aide care plans and completing rehab potential. The initial training program has alreadybegun and is scheduled to run six weeks. Upon completion of initial training program, Administrator and ExecutiveDirector will determine the second phase of the re-education and trainingprogram to ascertain if weekly trainings are still necessary, or if thefrequency of	

	and movement in all four limbs, the trunk, and face), Neuromuscular scoliosis (a sideways curvature of the spine), Localization-related (focal) (partial) symptomatic epilepsy (a condition caused by certain brain activity causing seizure activity). The section titled "Goals/Rehabilitation Potential/Discharge Plans" indicated goals were left blank, rehabilitation potential fair, and discharge plans when services are no longer authorized by payer. The plan of care failed to be patient-specific, failed to provide clinical directions to clinicians providing care, and failed to list any goals for Patient #1. During an interview on 02-09-2024 at 7:10 AM, when queried regarding their involvement in the plan of care, Registered Nurse (RN)1, a family member of Patient #1, indicated the Clinical Manager had come to the home to review Patient 1's medication but did not review or involve RN 1 in the plan of care. 3. During an interview on 02-08-2024 at 1:57 PM, the Clinical Manager confirmed no		the trainings may be reduced. Patient care is the top priority, and if nurse performance, through thereview of newly performed assessments, plans of care and nurse documentation,indicates that deficiencies in this process still exist, as related to thecomprehensive assessment, care planning coordination of care and quality ofcare processes, trainings will continue on a weekly basis. Nurses will be held accountable to the standardthat all sections of the comprehensive assessment and plan of care processesand the Clinical Manager and Alternate Clinical Manager will be responsible forensuring that the standards are being met and that agency remains incompliance. Any deficiencies found byclinical management will be addressed with the attending nurse who will beresponsible for correcting said deficiencies within 24 hours and to reportthose corrections to clinical management for further review. Clinical management will report directly tothe Administrator and Executive Director on this plan of correction. This deficient practice had the potential	

	goals were listed on the plan of care, and there was not a seizure plan in place for Patient #1. 4. A review of the clinical record for Patient #3, contained a recertification comprehensive assessment dated 01-25-2024, and electronically signed by RN 3. The comprehensive assessment failed to contain patient-specific goals and address progress toward any goals, and discharge planning was marked as not applicable (NA). A review of the plan of care for the recertification period from 01-30-2024 to 03-29-2024, indicated but was not limited to diagnoses, Chronic kidney disease (the failure of the kidney to filter wastes and excess fluid from your blood), Dependence on supplemental oxygen, Diabetes mellitus with diabetic neuropathy (a condition caused by long-term elevated blood sugars causing nerve damage) and Anemia in chronic kidney disease (a condition where the red blood cell count is low due to impaired kidney function). The plan of care indicated orders for		toaffect all patients, and therefore, all patient assessments and plans of carewill be held to this standard and corrected during each patient's nextscheduled re-certification visit. Theagency continues to identify the patients who were referenced within thestatement of deficiencies and is documenting such to ensure that each of thesedeficient items are addressed during the next scheduled re-certification visit. Regarding the coordination of care with otheragencies, an additional plan of correction has been put into place to assist inidentifying not just some, but all joint providers, and the Alternate ClinicalDirector is responsible for completing this plan of correction with oversightfrom Clinical Director and Administrator. A new form has been formulated and implemented which is being used toidentify and document all joint providers. The Alternate Clinical Director is contacting each patient to updatetheir provider list which can be utilized by other nurses and social workerwhen visiting patients. New protocolwill require that this form be taken	

	Attendant Care for 65 to 60 hours weekly and a Home Health Aide hourly for 91 hours a week but failed to treatment, and patient-specific goals The section titled "Problems/Interventions/Goals" indicated the patient's stated goal was no hospitalizations or falls, rehabilitation potential fair, and discharge plans when services are no longer authorized by payer. The plan of care failed to identify patient-specific measurable outcomes, and goals that identified the patient's specific needs and failed to provide direction to the clinicians providing patient care. A review of home health aide visit notes dated 12-26-2023, 12-27-2023, 12-29-2023, 01-03-2024, 01-04, 01-07, 01-08, 01-09, 01-10, 01-11, 001-22, 01-25, 01-30, 01-31, 02-02, 02-04, 02-05, and 02-08-2024 were left blank with no tasks completed. The record failed to contain a home health aide care plan. During an interview on 02-12-2024 at 4:47 PM, RN 3 indicated they did not include		to each patient visit and updated toensure the list of joint providers is always up to date. The nurses have been re-educated that alljoint providers must be provided within the patient plan of care. The Clinical Manager has theultimate responsibility to ensure that this plan of correction isfollowed. To further ensure saidcorrection, the Administrator and Executive will perform additional qualityassurance checks on comprehensive assessments and plans of care, to include noless than 10% of assessments and plans of care performed, on a monthlybasis. This plan of correction willremain ongoing in nature and compliance threshold is 100%.	

	patients being long-term, and they did not know how to find out if there were other disciplines in the home. RN 3 further indicated they were to include goals in care planning, and they were to complete rehab potential. When queried regarding the Home Health Aide care plan for Patient #3, indicated Patient #3 had an Attendant care for errands, and assists with showers, they were unaware of the Home Health Aide for Patient #3. 5. During an interview on 02-12-2024 at 5:08 PM, the Clinical Manager confirmed Patient #3 had a Home Health Aide. When queried regarding the Home Health Adie care plan the Clinical Manager confirmed there was no Home Health Aide care plan in Patient #3's record. 6. A review of the clinical record for Patient #6 contained a comprehensive reassessment dated 01-15-2024, electronically signed by the Clinical Manager. The comprehensive assessment indicated in the section titled "Problems/Interventions/Goals" was left blank. The assessment failed to include patient-specific measurable goals and discharge			

	planning. A review of the plan of care for the recertification period from 01-10-2024 to 03-09-2024, indicated The plan of care indicated but was not limited to diagnoses, Chronic combined systolic (congestive) and diastolic heart failure (the heart's inability to pump blood to the rest of the body), Chronic atrial fibrillation (an irregular and often rapid heart rhythm that can lead to blood clots), Pain in the right knee, and Essential hypertension (high blood pressure). The record contained a recertification comprehensive assessment dated 01-15-2024, electronically signed by the Clinical Manager. The plan of care failed to identify patient-specific measurable outcomes, goals that identified the patient's specific needs, and failed to provide direction to the clinicians providing patient care.			

	During an interview on 02-12-2024 at 1:00 PM, when they were shown the care plans for the patients, the Executive Director, Admin 2, indicated they saw no goals on the patient's care plans. 7. A focused review of the clinical record of Patient #11, contained a comprehensive reassessment, dated 02-07-2024 electronically signed by the Clinical Manager. The comprehensive reassessment indicated in the section titled "Problems/Interventions/Goals" was left blank. The comprehensive reassessment failed to contain patient-specific goals, address progress towards any goals, and discharge plans. A review of an incomplete plan of care for the recertification from 02-11-2023 to 04-10-2024, indicated but was not limited to diagnoses, Unspecified symptoms and signs involving functions following cerebral infarction (the effects of a stroke when the brain cells die when they do not get enough blood), Chronic diastolic (congestive) heart failure (the heart's inability to			

	pump blood to the rest of the body) and Chronic atrial fibrillation ((an irregular and often rapid heart rhythm that can lead to blood clots). During an interview on 08-12-2024 at 12:45 PM, the Executive Director, Admin 2, and the Clinical Manager confirmed there were no goals, or care preferences listed on the plan of care for Patients #1, 3, 6, and 11. 7. A review of Patient #4's clinical record evidenced a plan of care with a start of care date of 02-18-2019 and a recertification date from 01-23-2024 to 03-22-2024 and indicated a primary diagnosis of Multiple Sclerosis (a disease of the brain and spinal cord affecting speech and movement), Idiopathic peripheral autonomic neuropathy (a disease causing damage to the nervous system, causing pain and weakness in the body), Hypertensive heart disease (chronic high blood pressure causing changes in the heart), Chronic diastolic heart failure (the main pumping chamber in the heart becomes stiff and fails to fill with blood			

	properly), Hyponatremia (low sodium), Hypokalemia (low potassium), and Hyperlipidemia (high lipid levels, such as cholesterol). The plan of care evidenced the patient had a no-added salt diet. A review of the clinical record evidenced a document dated 08-22-2023, and it evidenced Patient #4 had allergies to the medications Lisinopril (a medication to lower blood pressure and Triamterene (a medication used to help increase the flow of urine and prevents the user from losing too much potassium). The Home Health Aide (HHA) plan of care (POC) dated 07-31-2023, indicated but was not limited to, " ... Allergies ... NKA – No Known Allergies ...". The assessment failed to ensure the patient's allergies were listed. The HHA POC failed to indicate the patient had a no-salt-added diet. The HHA POC failed to be updated every 60 days. The HHA POC failed to evidence patient-specific and measurable goals for the patient. 8. A review of Patient #5's clinical record evidenced a Home Health Aide (HHA) plan of care (POC) dated 07-31-2023. The HHA POC failed to be			

	updated at least every 60 days according to the agency's policy. The HHA POC evidenced the patient had a diagnosis of Quadriplegia (paralysis of all 4 limbs). The clinical record evidenced a plan of care, with a start of care date of 11-13-2019 and a recertification date from 12-22-2023 to 02-19-2024, and indicated a primary diagnosis of Quadriplegia (paralysis of all 4 limbs), Multiple Sclerosis (a disease of the brain and spinal cord affecting speech and movement), Ataxia (loss of muscle coordination), and Contracture of muscle. The plan of care, dated 12-18-2023 by the Clinical Manager (Admin) 3, evidenced a section titled "60 Day Summary" and indicated the patient had increased difficulty and pain when swallowing food. The HHA POC failed to evidence the patient was at risk of aspiration (when food or liquid enters a person's airway). The HHA POC failed to evidence the durable medical equipment (DME) used to care for the patient. The HHA POC failed to evidence the safety measures to promote skin integrity for an individual with a diagnosis of Quadriplegia. The plan of care failed to identify			

	patient-specific measurable goals, identified the patient's specific needs, and failed to provide direction to the clinicians providing patient care. 9. A review of Patient #14's POC with a start of care date of 12-30-2023 and a certification period from 12-20-2023 to 02-17-2024. The POC was signed by Registered Nurse (RN) 3 on 01-01-2024. The POC failed to be completed and signed by a physician according to the agency policy. The plan of care failed to include patient-specific and measurable goals, identified the patient's needs, and failed to direct the clinicians providing care. 10. During an interview with Admin 3 on 02-09-2024 at 12:45 PM, they indicated the HHA POC included frequency and duration of tasks, goals, interventions, and safety measures to ensure the HHA was aware of the patient's needs. 11. During an interview with Admin 3 on 02-12-2024 at 3:28 PM, they indicated the HHA POC was only updated as needed and as the patient's			

	condition warranted. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (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	G0574	The agency has launched anextensive nurse training program in which nurses and leadership are meeting ona weekly basis so that nurses, including Clinical Manager and AlternateClinical Manager, can be in-serviced and re-trained on the process ofcomprehensive assessments and plans of care. Nurses are being re-trained bothindividually and in group sessions, step-by-step through each section of thecomprehensive assessment process as previously noted in prior deficiencyresponses G0572, G0570, G0534, G0530 and G0528. The comprehensive assessment drives the plan of care process and flowsthrough to the plan of care document within the electronic health record. During training, nurses are being re-educatedon the flow of this process and how an area of deficiency within thecomprehensive assessment will also result in deficiency within the plan ofcare. Regarding nurse training andre-education as related to	2024-02-28

	or allowed practitioner may choose to include. Based on observation, record review, and interview, the agency failed to ensure the individualized plan of care included all diagnoses, all supplies and equipment, frequency and duration of visits made, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all medications and treatments, safety measures to protect against injury, a description of the patient's risk for emergency department visits and hospital readmission, and all underlying risk factors, patient and caregiver education and training, and patient-specific interventions and education, measurable outcomes and goals identified by the agency in 5 of 6 active records reviewed (Patients: #1, 2, 3, 4, and 5) and 6 of 6 focused records reviewed. (Patients: #9, 10, 11, 12, 13, and 14) Findings Include: 10. During a home visit at the residence of Patient #1 on 02-09-2024 at 7:00 AM, the Registered Nurse (RN) 1, a family member of Patient #1, indicated they manage the feedings, and patient's medications (given by g-tube). RN 1 was observed demonstrating Patient#1's specialty bed that assists with		the plans of care, they are being re-trained onitems to include, but not be limited to, regulation that all plans of care mustinclude all pertinent diagnosis; patient's mental, psychosocial and cognitivestatus; the types of services, supplies and equipment required; the frequencyand duration of visits to be made; prognosis; rehabilitation potential;functional limitations; activities permitted; nutritional requirements; allmedications and treatments (to include allergies); safety measures to protectagainst injury; a description of patient's risk for emergency department visitsand hospital re-admission, and all necessary interventions to address theunderlying risk factors; patient and caregiver education and training tofacilitate timely discharge; patient-specific interventions and education,measurable outcomes and goals identified by the home health agency and thepatient; information related to any advanced directives, and any additionalitems the HHA or physician or allowed practitioner may choose to include. Nurses have also been	

	the ceiling track surrounding the bed and bathroom facilitates safe transfers in a sling to lift Patient #1 from their bed to a standing position or their wheelchair, shower chair, or the bathroom. RN 1 indicated Patient #1 had a manual Hoyer in the other room. Patient #1 was observed in bed wearing depends and was lying on a chuck. RN #1 indicated Patient #1 had their last seizure in October 2023 and has as-needed Diazepam nasal and oral that can be given. Observed a Jacuzzi hot tub with a ramp and handicapped accessibility in the back of the house in another room. RN 1 indicated they had the addition to the house to assist in meeting Patient #1's needs. RN 1 confirmed Patient #1 loves getting in it. Observed Patient#1's bedroom led to their bathroom. The Bathroom had floor drains with a wall shower with a handheld shower head, a whirlpool tub, a washer and dryer, a toilet, and a large utility sink basin. Observed on the top of the dresser a nebulizer and suction machine. A review of a plan of care for the recertification period from		re-educated on thedifference between a skilled patient versus a non-skilled patient and when toutilize a skilled patient assessment versus a non-skilled patientassessment. The initial training programhas already begun and is scheduled to run six weeks. Upon completion of initial training program,Administrator and Executive Director will determine the second phase of there-education and training program to ascertain if weekly trainings are stillnecessary, or if the frequency of the trainings may be reduced. Patient care is the top priority, and ifnurse performance, through the review of newly performed assessments, plans ofcare and nurse documentation, indicates that deficiencies in this process stillexist, as related to the comprehensive assessment and care planning, trainingswill continue on a weekly basis. Nurseswill be held accountable to the standard that all sections of the comprehensiveassessment and plan of care processes and the Clinical Manager and AlternateClinical Manager will be responsible for ensuring that the standards are beingmet and	

	01-16-2024 to 03-15-2024, indicated but was not limited to diagnoses, Spastic quadriplegic cerebral palsy (a condition that affects the ability to control muscles and movement in all four limbs, the trunk, and face), Neuromuscular scoliosis (a sideways curvature of the spine), Localization-related (focal) (partial) symptomatic epilepsy (a condition caused by certain brain activity causing seizure activity). The plan of care section (Durable Medical Equipment) DME and Supplies evidenced wheelchair, hospital bed, shower bench, Hoyer lift, and feeding pump; Orders for Discipline and Treatment (Specify Amount /Frequency/Duration) evidenced Respite RN 60 hours monthly for 1 certification period, RN hourly 76 hours weekly for 1 certification period, and RN recertification OASIS 1 visit for 1 certification period; Problems and Interventions evidenced no documented interventions and no problems; Goals/Rehabilitation Potential/Discharge Plans evidenced no goals, fair rehabilitation potential, and discharge plans indicated when services are no longer		that agency remains in compliance. Any deficiencies found by clinical managementwill be addressed with the attending nurse who will be responsible forcorrecting said deficiencies within 24 hours and to report those corrections toclinical management for further review. Clinical management will report directly to the Administrator andExecutive Director on this plan of correction. This deficient practice had the potential to affect all patients, andtherefore, all patient assessments and plans of care will be held to thisstandard and corrected during each patient's next scheduled re-certificationvisit. The agency continues to identifythe patients who were referenced within the statement of deficiencies and isdocumenting such to ensure that each of these deficient items are addressed duringthe next scheduled re-certification visit. In addition to the Clinical Director and/or Alternate Clinical Directorperforming quality assurance on plans of care via the electronic health record,an additional new form has been formulated and implemented which is being	

	authorized. The plan of care failed to include all DME and medical supplies including, feedings, feeding supplies, briefs, pads, ceiling tracking slip, Jacuzzi tub, whirlpool bath, handheld wall shower, nebulizer, suction machine, and motorized wheelchair; failed to include specific frequency, treatments, and duration; failed to include RN interventions, patient-specific problems, and risk factors to include addressing seizure plans; failed to include measurable goals; failed to include Patient #1's risk for emergency room visits and hospital admissions; failed to address specific education and training provided. 11. A review of the clinical record on 02-12-2024, for Patient #2, with a start of care date of 07-08-2017, contained a plan of care for the recertification period of 02-02-2023 through 04-01-2024. The plan of care indicated but was not limited to diagnoses, Cerebral palsy (a condition that affects the ability to control muscles and movement), Moderate intellectual disabilities, and Epilepsy (a condition caused by		usedto further document deficiencies during the quality assurance process. This form will be provided to the attendingnurse(s) when a deficiency is identified and needs correction. The Clinical Manager has theultimate responsibility to ensure that this plan of correction isfollowed. To further ensure saidcorrection, the Administrator and Executive will perform additional qualityassurance checks on comprehensive assessments and plans of care, to include noless than 10% of assessments and plans of care performed, on a monthlybasis. This plan of correction willremain ongoing in nature and compliance threshold is 100%.	

	certain brain activity causing seizure activity). The plan of care section Orders for Discipline and Treatments (specify Amount/Frequency/Duration) evidenced Respite RN 27 hours weekly on Sunday, and Friday for 1 certification period; failed to give a specific frequency and duration; the section Goals evidenced fluid intake and output with expected range; failed to address the patient-specific goals; the section Discharge plans evidenced when services are no longer needed; failed to list patient-specific discharge planning; failed to include Patient #2's risk for emergency room visits and hospital admissions; failed to address specific education and training provided. On 02-12-2024 at 11:20 AM, a call was placed to RN 2, and a voicemail was left for a return call. No return calls were received. 12. A review of the clinical record for Patient #3 contained a plan of care for the recertification period			

	plan of care indicated but was not limited to diagnoses, Chronic kidney disease (the failure of the kidney to filter wastes and excess fluid from your blood), Dependence on supplemental oxygen, Diabetes mellitus with diabetic neuropathy (a condition caused by long-term elevated blood sugars causing nerve damage) and Anemia in chronic kidney disease (a condition where the red blood cell count is low due to impaired kidney function). The section Medications/Dose/Route/Frequency indicated but was not limited to, Humalog (medication to lower blood sugar) Pen Injector 100 units/milliliter (ml)/100 units/1ml subcutaneous once a day, and Insulin Glargine (a medication used to lower blood sugar) 100units/ml subcutaneous/give 77 units once a day; (Durable Medical Equipment) DME and Supplies evidenced cane, walker, shower bench, bath safety bars, hazardous waste container, oxygen, and electric wheelchair; Orders for Disciplines and Treatments (Specify Amount/Frequency/Duration) evidenced Attendant 65-69			

	hours weekly for 1 certification period, and Home Health Aide (HHA) Hourly 91 hours weekly for 1 certification period; Problems and Interventions evidenced Patient #3's main goal is to be able to remain in their apartment and not go to an assisted living; Goals/Rehabilitation Potential/Discharge Plans evidenced no goals, fair rehabilitation potential, and discharge plans indicated when services are no longer authorized by payer. The plan of care failed to include all DME and medical supplies including, insulin pen needles, glucometer, lancets, and glucometer strips; failed to include specific HHA and Attendant frequency, treatments, and duration; failed to include HHA and Attendant care interventions, patient-specific problems, and risk factors to include diabetes and renal function; failed to include measurable goals; failed to include Patient #3's risk for emergency room visits and hospital admissions; failed to address specific education and training provided. 13. A focused review of the			

	plan of care for the recertification from 02-11-2023 to 04-10-2024, indicated but was not limited to diagnoses, Unspecified symptoms and signs involving functions following cerebral infarction (the effects of a stroke when the brain cells die when they do not get enough blood), Chronic diastolic (congestive) heart failure (the heart's inability to pump blood to the rest of the body) and Chronic atrial fibrillation ((an irregular and often rapid heart rhythm that can lead to blood clots). The section DME and Supplies left blank; Safety Measures left blank; Functional Limitations left blank; Activities Permitted left blank; Metal status left blank; Order for Disciplines and Treatments (Specify Amount/Frequency/Duration) evidenced HHA 56 hours weekly for 1 certification period, RN Recertification non-oasis 1 visit for the certification period; and Problems and Interventions, left blank; Goals/Rehabilitation Potential/Discharge Plans left blank. The plan of care failed to include DME and medical supplies; failed to have Safety Measures; failed to have Functional Limitations; failed to			

	have Activities permitted; failed to include specific HHA frequency, treatments, and duration; failed to include HHA interventions, patient-specific problems, and risk factors to include diabetes and renal function; failed to include measurable goals; failed to include Patient #11's risk for emergency room visits and hospital admissions; failed to address specific education and training provided. 14. A focused review of the clinical record of Patient #12 contained an incomplete plan of care for the recertification from 01-26-2023 to 03-25-2024, indicated but was not limited to diagnoses, Cerebral palsy (a condition that affects the ability to control muscles and movement) and Unspecified intellectual disabilities. The section Order for Disciplines and Treatments (Specify Amount/Frequency/Duration) evidenced HHA 42 hours weekly for 1 certification period, RN Recertification non-oasis 1 visit for the certification period; but failed to have specific HHA frequency and duration.			

	During an interview on 02-12-2024 at 1:00 PM, the Executive Director, Admin 2, and the Clinical Manager confirmed the plan of cares were incomplete. Admin 2 further indicated the nurses were completing the incorrect assessments. 410 IAC 17-13-1(a)(1)(D)(i, ii, iii, iv, v, vi, vii, vii, ix, x, xi, xii, xiv) 1. An agency policy revised October 2016 and titled "Care Planning Process", Policy No. 4-001.1, indicated but was not, " ... Policy ... the patient plan of care will be developed or revised within five (5) working days of initiation of each service or of the reassessment of the patient ... 1. Plan of Care ... includes: ... D. Pertinent primary and secondary diagnoses, E. Food or drug allergies, F. Homebound status, G. Goals/outcomes to be achieved, H. Patient's mental status, I. Functional limitations, J. Activities permitted, K. Safety measures, L. Nutritional requirements, M. Medications including dose/frequency/route, N. orders for specific home health services and disciplines, treatments and procedures,			

	including amount/frequency/duration, O. Supplies and equipment required, P. Discharge or referral plans, Q. Discharge teaching, R. Frequency and duration of visits, S. Prognosis, T. Rehabilitation potential ..." 2. A review of Patient #4's clinical record evidenced a POC with a start of care date of 02-18-2019 and a recertification date from 01-23-2024 to 03-22-2024 and indicated a primary diagnosis of Multiple Sclerosis (a disease of the brain and spinal cord affecting speech and movement), Idiopathic peripheral autonomic neuropathy (a disease causing damage to the nervous system, causing pain and weakness in the body), Hypertensive heart disease (chronic high blood pressure causing changes in the heart), Chronic diastolic heart failure (the main pumping chamber in the heart becomes stiff and fails to fill with blood properly), Hyponatremia (low sodium), Hypokalemia (low potassium), and Hyperlipidemia (high lipid levels, such as cholesterol). A review of the clinical record evidenced a document dated 08-22-2023,			

and it evidenced Patient #4 had allergies to the medications Lisinopril (a medication to lower blood pressure and Triamterene (a medication used to help increase the flow of urine and prevents the user from losing too much potassium). The Home Health Aide (HHA) POC dated 07-31-2023, indicated but was not limited to, " ... Allergies ... NKA – No Known Allergies ..." The POC failed to include all the patient's allergies. The POC indicated the patient had Home Health Aide (HHA) services 20 hours a week. The POC failed to indicate the frequency and duration of each visit and the care provided to the patient. The interventions failed to evidence the treatments and education provided to the patient. The POC evidenced the patient's goal was to be free from seizures and free from falls. The goals listed in the POC included, the patient performed tasks with assistance safely, demonstrated proper body mechanics with transfers and ambulating, and followed their home exercise program. The goals failed to be patient-specific and measurable.

G0590	Promptly alert relevant physician of changes 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. Based on record review and interview, the skilled nurse failed to promptly notify the physician of changes in the patient's condition in 1 of 1 patients with a change in condition. (Patient: #2) Findings include: 1. An agency policy, with a revision date of October 2016, titled "Monitoring Patient's Response/Reporting To Physician" indicated but was not limited to. " ... 3. The patient's physician will be contacted on the same day when any of the following occur: A. Significant changes in condition ... 4. All conferences or attempts to communicate with the physician will be documented in the clinical record ... " 2. A review of the clinical record on 02-12-2024, for Patient #2, with a start of care date of 07-08-2017, and a recertification period of	G0590	Agency leadership has re-educatedRN #2, as well as all nurses, on their responsibility to promptly notify apatient's relevant physician when there is a significant change incondition. The clinical manager notifiedthe relevant physician regarding the change in condition for Patient #2. This deficient practice has the potential toaffect all patients and nurses have been re-educated and trained on process tofollow regarding notification of physicians. To ensure this deficient practice does not again occur, the ClinicalManager and/or Alternate Clinical Manager will now have a new process tocontact nurses following each scheduled visit to discuss outcome of visit, aswell as any possible changes to patient condition. Office team members have been educated on howto handle and dispatch calls that are related to patients and changes incondition. Clinical Director and/orAlternate Clinical Director will report any changes to multi-disciplinary teamand leadership team during morning meetings and quality improvementmeetings. The Administrator andExecutive Director will monitor Clinical	2024-02-28

	02-02-2023 through 04-01-2024, evidenced by an agency document titled, "Client Logging Report" dated 02-07-2024. The document indicated a call had been placed to contact the family regarding permission for a Surveyor visit on 02-09-2024. The document further indicated the home health aide just found out Patient #2 and their family all had COVID. The record failed to evidence any documentation of notification to the physician regarding Patient #2's change in condition. During an interview on 02-12-2024 at 10:24 AM, the Clinical Manager, when queried regarding Patient #2's physician being notified by the nurse or agency of the Patient's change in condition confirmed there had been no notification to the physician regarding Patient #3 having COVID. The Clinical Manager further indicated the Registered Nurse (RN) for Patient #2, RN 2, had been in earlier that day at the agency to pick up Personal Protective Equipment for their visit. 3. On 02-12-2024 at 11:20 AM, a call was placed to RN 2,		Leadership on this plan of correction,by performing quality assurance on no less than 10% of patient visits permonth. This plan of correction willremain ongoing in nature and the threshold for compliance is 100%.	

	received no answer, and a voicemail was left for a return call. No return calls. 4. On 02-12-2024 at 11:22 AM, a call was placed to Person 2, Patient #2's family member, received no answer, and a voicemail was left for a return call. No return calls. 5. During an interview on 01-12-2024 at 12:45 PM, the Clinical Manager notified the surveyor that Patient #2 was seen at Entity 10, an acute care facility, on 02-07-2024 and tested positive for COVID-19. 410 IAC 17-13-1(a)(2)			
G0606	Integrate all services 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. Based on record review and interview, the agency failed to ensure the patients' overall health and goals were discussed in the multidisciplinary team for 5 of 6 active clinical records reviewed (Patients #1, 2, 3, 4, and 5) and 4	G0606	The agency has launched anextensive nurse training program in which nurses and leadership are meeting ona weekly basis so that nurses, including Clinical Manager and AlternateClinical Manager, can be in-serviced and re-trained on the process ofcomprehensive assessments, care planning and the integration of all services. Nursesare being re-trained both individually and in group sessions, step-by-stepthrough each section of the	2024-03-12

	of 6 focused audit clinical records reviewed. (Patients: # 9, 10, 13, and 14) Findings Include: 10. On 02-07-2024 at 10:55 AM, during the Entrance Conference, when queried on how care is coordinated within the agency, the Executive Director, Admin 2, indicated the nurses and social worker address coordination of care in the section of their electronic medical record titled "Client Logging." 11. A review of the clinical record for Patient #1, start of care date of 11-17-2024, contained a plan of care for the recertification period from 01-16-2024 to 03-15-2024. The plan of care indicated but was not limited to diagnoses, Spastic quadriplegic cerebral palsy (a condition that affects the ability to control muscles and movement in all four limbs, the trunk, and face), Neuromuscular scoliosis (a sideways curvature of the spine), Localization-related (focal) (partial) symptomatic epilepsy (a condition caused by certain brain activity causing seizure activity).		comprehensive assessment process. This training process for integrating allservices includes, but is not limited to, conducting multi-disciplinarymeetings to ensure that patients' overall health and goals are being met;ensuring said multi-disciplinary meetings are being conducted following thestart of care and following each re-certification visit; ensuring that multi-disciplinarycase conferences include topics such as physical status of the patient,interventions for all disciplines and patient response, teaching plan and itseffectiveness, progress toward goals, joint providers who are also servicingthe patient, preferences of the patient, any necessary or recommended changesto patient treatment, appropriately communicating and documentation of suchcommunication with relevant physician and other multi-disciplinary members;actively reviewing patient clinical records, both prior to visits and aftervisits; remaining engaged with the patients in between routine	

	A review of the comprehensive reassessment dated 01-12-2023 and electronically signed by the Clinical Manager contained a section titled “Interdisciplinary Communication” indicated that communication with the physician was answered no, and communication with others was answered no. The clinical record failed to evidence case conference between the Clinical Manager and RN 1 discussing the patient’s progress toward their goals and any changes needed to the plan of care. During a home visit at Patient#1’s residence on 02-12-2024 at 7:10 AM, RN 1, when queried if they were aware of goals on the plan of care and progress towards those goals, indicated they were not involved in the plan of care reviews. 12. A review of the clinical record for Patient #2, start of care 07-08-2017, contained a plan of care for the recertification period from 02-02-2024 to 04-01-2024. The plan of care indicated but was not limited to diagnoses, Cerebral palsy (a condition that affects the ability to control		visits; and involvingpatient and family in all areas of the care planning process, and in particulartheir progress toward goals and any requested or necessary changes to the planof care. The statement of deficienciesreferences that nurses and social worker document coordination of care underthe “client logging” section of the electronic health record. The agency staff members do document suchcommunication on coordination of care in this section for those clients whoreceive Integrated Health Care Coordination through Medicaid Waiverprogram. Case conferences are not documentedin this section and nurses have been educated that all case conferences, regardlessof the service or payer source, should also be documented under casecommunication of the electronic health record. Upon completion of initial training program, Administrator and ExecutiveDirector will determine the second phase of the re-education and trainingprogram to ascertain if weekly trainings are still necessary, or if thefrequency of	

	muscles and movement), Moderate intellectual disabilities, Contracture left hand (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that cause the joints to shorten and stiffen), Contracture right hand, and Epilepsy (a condition caused by certain brain activity causing seizure activity). A review of the comprehensive reassessment dated 01-27-2024, electronically signed by RN 2, contained a section titled "Interdisciplinary Communication" indicated that communication with the physician was answered no, and communication with others was answered no. The clinical record failed to evidence case conference between the Clinical Manager and RN 2 discussing the patient's progress toward their goals and any changes needed to the plan of care. On 02-12-2024 at 11:20 a call was placed to RN 2, and a message was left for a return call. No return calls. 13. A review of the clinical record for Patient #3, start of care 04-05-2023, contained a		the trainings may be reduced. Patient care is the top priority, and if nurse performance, through thereview of newly performed assessments, plans of care and case conferences indicatesthat deficiencies in these processes still exist, trainings will continue on aweekly basis. Nurses will be heldaccountable to the standard that all sections of the comprehensive assessmentand plans of care, as well as the standard to hold case conferences with eachstart of care, resumption of care and/or re-certification of care. The Clinical Manager and Alternate ClinicalManager will be responsible for ensuring that a case conference is conductedfor each of the preceding and that there is appropriate documentation of suchwithin each patient's electronic health record. This deficient practice had the potential toaffect all patients and the Clinical Manager has the ultimate responsibility toensure that this plan of correction is followed. To further ensure said plan of correction,the Administrator and Executive will perform monthly quality assurance checks onno less than 10% of	

	plan of care for the recertification period from 01-03-2024 to 03-29-2024. The plan of care indicated but was not limited to diagnoses, Chronic kidney disease (the failure of the kidney to filter wastes and excess fluid from your blood), Dependence on supplemental oxygen, Diabetes mellitus with diabetic neuropathy (a condition caused by long-term elevated blood sugars causing nerve damage) and Anemia in chronic kidney disease (a condition where the red blood cell count is low due to impaired kidney function).		patient records. Thisplan of correction will remain ongoing in nature and compliance threshold is100%.	

	A review of the comprehensive reassessment dated 01-25-2024, electronically signed by RN 3, contained a section titled "Interdisciplinary Communication" indicated that communication with the physician was answered no, and communication with others was answered no. The clinical record failed to evidence case conference between the Clinical Manager, RN 3, the Home Health Aide (HHA) 1, HHA 5, and Attendant 4, discussing the patient's progress toward their goals and any changes needed to the plan of care. During an interview on 02-12-2024 at 4:47 PM, RN 3 indicated they did not know Patient #3 had around-the-clock care being provided by a HHA and Attendant. 410 IAC 17-12-2(g) 1. An agency policy revised October 2016 titled "Case Conference/Progress Summary" indicated but was not limited to, " ... Case conferences will be held at the start of care and at least every 60 days to review			

	cases ... Procedure ... 2. For each patient, the Case Manager will lead the conference and discuss: A. Physical status of the patient ... E. Interventions for all disciplines and patient response, F. Teaching plan and its effectiveness, G. Progress toward goals ..." 2. A review of Patient #4's clinical record evidenced a plan of care with a start of care date of 02-18-2019 and a recertification date from 01-23-2024 to 03-22-2024 and indicated a primary diagnosis of Multiple Sclerosis (a disease of the brain and spinal cord affecting speech and movement), Idiopathic peripheral autonomic neuropathy (a disease causing damage to the nervous system, causing pain and weakness in the body), Hypertensive heart disease (chronic high blood pressure causing changes in the heart), Chronic diastolic heart failure (the main pumping chamber in the heart becomes stiff and fails to fill with blood properly), Hyponatremia (low sodium), Hypokalemia (low potassium), and Hyperlipidemia (high lipid levels, such as cholesterol). The clinical record			

failed to evidence a case conference between the agency team members discussing the patient's progress toward their goals and any necessary changes to their treatment.

3. A review of Patient #5's clinical record evidenced a plan of care, with a start of care date of 11-13-2019 and a recertification date from 12-22-2023 to 02-19-2024 and indicated a primary diagnosis of Quadriplegia (paralysis of all 4 limbs), Multiple Sclerosis (a disease of the brain and spinal cord affecting speech and movement), Ataxia (loss of muscle coordination), and Contracture of muscle. The clinical record failed to evidence a case conference between the agency team members discussing the patient's progress toward their goals and any necessary changes to their treatment.

4. A review of Patient #9's clinical record evidenced a plan of care with a start of care date of 12-01-2018 and a recertification date from 01-04-2024 to 03-03-2024 and indicated a primary diagnosis of

	replacement surgery, gait and mobility abnormalities, history of falling, Right artificial hip joint, pain in left hip, pain in right shoulder, Anemia (low level of red blood cells), Hypertension (high blood pressure), and a history of Transient Ischemic Attack (a brief interruption of blood to the brain). The clinical record failed to evidence a case conference between the agency team members discussing the patient's progress toward their goals and any necessary changes to their treatment. 5. A review of Patient #10's clinical record evidenced a plan of care with a start of care date of 06-09-2019 and a recertification date from 01-14-2024 to 03-13-2024 and evidenced diagnoses of Autistic disorder (a developmental disability), speech disturbances, and behavioral and emotional disorders. The clinical record failed to evidence a case conference between the agency team members discussing the patient's progress toward their goals and any necessary changes to their treatment. 6. A review of Patient #13's			

	clinical record evidenced a plan of care with a start of care date of 10-12-2022 and a recertification date from 02-04-2024 to 04-03-2024 and evidenced the diagnoses Chronic kidney disease, stage 5, unilateral osteoarthritis in the right hip (a disease where tissue in the right hip joint breaks down over time), chronic pain, Hypertension (high blood pressure), muscle weakness, and Benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate, with frequent urination or a weak stream). The clinical record failed to evidence a case conference between the agency team members discussing the patient's progress toward their goals and any necessary changes to their treatment. 7. A review of Patient #14's clinical record evidenced a comprehensive assessment dated 12-30-2023, by Registered Nurse (RN) 3, and it failed to evidence a list of the patient's diagnoses. The clinical record failed to evidence a case conference between the agency team members discussing the patient's progress toward their goals and any necessary			

	changes to their treatment. 8. During an interview with the Clinical Manager (Admin) 3 on 02-12-2024 at 1:43 PM, they indicated they had never done a case conference with the team for patients. 9. During an interview with Registered Nurse (RN) 3 on 02-12-2024 at 4:38 PM, they indicated they had never done a case conference with the team for patients.			
G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview, the agency failed to ensure that the patient's clinical records included information about the services the patient received from other health providers and failed to ensure they coordinated care delivery to meet the patient's needs for 3 of 6 active patient records reviewed. (Patients: #2, 3, and 5) Findings Include:	G0608	**G0608 Coordinate Care Delivery** The agency has launched anextensive nurse training program in which nurses and leadership are meeting ona weekly basis so that nurses, including Clinical Manager and AlternateClinical Manager, can be in-serviced and re-trained on the process ofcomprehensive assessments, care planning, the integration of all services andthe coordination of care delivery. Nurses are being re-trained bothindividually and in group sessions, step-by-step through each step ofcoordinating care delivery.	2024-03-12

	1. An agency policy with a revision date of October 2016, titled "Coordination of Services with Other Providers" indicated but was not limited to, " ... A Case Manager will be assigned to be responsible for coordinating services provided to the patient by the organization, including services provided directly and through contract. The Case Manager will act as a liaison with other organizations or individuals also providing care to the patient to assure effective coordination of related services ... " 2. On 02-07-2024 at 10:55 AM, during the Entrance Conference, when queried on how care is coordinated with other agencies, the Executive Director, Admin 2, indicated the nurses and social worker address coordination of care in the section of their electronic medical record titled "Client Logging." 3. A review of the clinical record for Patient #3, the start of care of 07-08-2017, contained a plan of care for the recertification period of 02-02-2024 to 04-01-2024. The plan of care indicated that Patient #2		Thistraining process for integrating and coordinating care delivery all servicesincludes, but is not limited to, conducting multi-disciplinary meetings toensure that patients' overall health and goals are being met; ensuring thatmembers of the multi-disciplinary team, whether agency employees or jointproviders, are receiving frequent communication regarding patient's overallhealth status, any significant changes, recent or upcoming physician visits,the need for and receipt of any new durable medical equipment, changes inliving arrangements, changes in care providers and any other pertinentinformation related to the patient. Thestatement of deficiencies references that nurses and social worker documentcoordination of care under the "client logging" section of the electronichealth record. The agency staff membersdo document such communication on coordination of care in this section forthose clients who receive Integrated Health Care Coordination through MedicaidWaiver program. Case conferences are	

	attends Entity 3, an adult day care facility when services as available staffing permits. A review of agency documents titled "Client Logging Report" dated 01-23-2024 to 02-12-2024, failed to evidence documentation of coordination of care with Entity 3. During an interview on 02-12-2024 at 4:07 PM, Person 4, a Registered Nurse (RN) at Entity 3, an adult day care, indicated Patient #3 attends their daycare program when transportation is available. Person 4 further confirmed they had no documentation of communication from Acme Health Services Incorporated coordinating care. 4. On 02-12-2024 at 11:20 AM, a call was placed to RN 2, the nurse for Patient #3. A voicemail was left for a return call. No return calls. 5. On 02-12-2024 at 11:22 AM, a call was placed to Person 2, the caregiver and family member of Patient #3. A voicemail was left for a return call. No return calls. 6. A review of the clinical record		notdocumented in this section and nurses have been educated that all caseconferences, regardless of the service or payer source, should also bedocumented under case communication of the electronic health record. To ensure that this deficient practice doesnot again occur, a new form "joint provider listing" has been formulated andimplemented and the Alternate Clinical Director is communicating with allpatients and/or their authorized representatives to ensure that the agency hasa current list of all joint providers. For the purposes of defining "joint provider," this may include, but notbe limited to, other home health agencies, personal service agencies, dialysisclinics, coumadin clinics, IV infusion services, adult day programs, assistedliving facilities, adult family care homes, waiver case managers, relevantphysicians, social workers and mental health counselors and practitioners,transportation providers, emergency response systems, home delivered meals,providers of durable medical equipment, pharmacies, providers of diabeticsupplies	

	for Patient #6, the start of care of 04-05-2023, contained a plan of care for the recertification period of 01-30-2024 to 03-29-2024. The plan of care indicated that Patient #6 goes to Entity 8, an incenter dialysis treatment facility, three times a week. A review of agency documents titled "Client Logging Report" dated 01-23-2024 to 02-12-2024, failed to evidence documentation of coordination of care with Entity 8. During an interview on 02-12-2024 at 5:00 PM, Person 9, the Clinical Manager for Entity 8, confirmed Patient #6 received dialysis treatment every Tuesday, Thursday, and Saturday for 5 hours at Entity 8. Person 9 further confirmed Acme Health Services Incorporated, had not contacted them to coordinate care regarding Patient #6. 7. During a home visit on 02-09-2024 at 2:10 PM, Person 20, Patient #5's relative, indicated Patient #5 had a case manager with Entity 1, an adult social services agency, and a personal services agency, Entity		and providers of incontinent supplies. The Alternate Clinical Director will complete this task and will ensurethat all providers are documented in the clinical record. Attending nurses will be required to take saidlisting to each patient visit and to review the listing with patient and/orauthorized representative and to update any changes. The attending nurse will further be requiredto document any changes within the patient's plan of care during there-certification process. Uponcompletion of initial training program, Administrator and Executive Directorwill determine the second phase of the re-education and training program toascertain if weekly trainings are still necessary, or if the frequency of thetrainings may be reduced. Patient careis the top priority, and if nurse performance, through the review of newlyperformed assessments, plans of care, coordination of care and case conferencesindicates that deficiencies in these processes still exist, trainings willcontinue on a weekly basis. The ClinicalManager and Alternate Clinical Manager will be responsible for ensuring that	

	12. A review of Patient #5's clinical record failed to evidence communication notes with Entity 1 and Entity 12. During an interview with Entity 12's owner, Person 13, on 02-12-2024 at 9:32 AM, they indicated the agency had never contacted them regarding Patient #5. They indicated Person 20 was the only individual they communicated with regarding Patient #5's care. During an interview with Patient #5's case manager, Person 11, with Entity 1 on 02-12-2024 at 9:42 AM, they indicated the agency had never contacted them regarding the patient. Person 11 indicated they were the ones to reach out to the agency. They indicated the agency was to follow up with Person 11 quarterly, but the agency had not contacted them. During an interview with the Executive Director (Admin) 2 on 02-12-2024 at 11:45 AM, they indicated they were unable to find communication notes for Patient #5.		theagency is compliance with the coordination of care delivery and that there isappropriate documentation of such within each patient's electronic healthrecord. This deficient practice had thepotential to affect all patients and the Clinical Manager has the ultimateresponsibility to ensure that this plan of correction is followed. To further ensure said plan of correction,the Administrator and Executive will perform monthly quality assurance checkson no less than 10% of patient records. This plan of correction will remain ongoing in nature and compliancethreshold is 100%.	

	410 IAC 17-14-1(a)(1)(F)			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on record review and interview, the agency failed to ensure the patient or the patient's caregiver were provided with a medication schedule/instructions, including medication name, dosage, and frequency in plain language in 3 of 3 home visit patients. (Patients: #1, 5, and 6) Findings Include: 1. During a home visit at the residence of Patient #1 on 02-09-2024 at 7:00 AM, RN 1, a family member of Patient #1, indicated they could not locate their binder. RN 1 when queried regarding a medication list being given, indicated the agency had not provided a medication list. 2. During a home visit at the residence of Patient #6 on 02-09-2024 at 10:30 AM, reviewed the patient's agency	G0616	The agency has launched anextensive nurse training program in which nurses and leadership are meeting ona weekly basis so that nurses, including Clinical Manager and AlternateClinical Manager, can be in-serviced and re-trained on all processes, includingpatient medication schedules and instructions. Nurses are being re-trained both individually and in group sessions, regardingpatient medication schedule and instructions. The statement of deficiencies has noted that medication schedules andinstructions were absent in the home of clients visited. It is agency policy that a medication profilebe completed upon every start of care and that said medication profile be leftin the home of the patient which may be found inside the patient's blue "Acmefolder." However, it is not uncommon forpatients to misplace these folders or to even dispose of them. As part of the agency's extensive nursetraining program, nurses are being re-educated on the importance of ensuringthat each patient has	2024-02-28

	folder. When queried regarding a plan of care and medication list Patient #6 indicated there is not one. The Medical Social Worker (MSW) indicated they did not bring the medication list or plan of care for Patient #6. During an interview on 02-12-202402-12-2024 at 10:20 AM, the Clinical Manager confirmed medication lists are not taken to the patients. 3. During a home visit at Patient #5's residence on 02-09-2024 at 2:10 PM for a home health aide (HHA) observation, the patient's admission packet failed to include the patient's medication list and schedule in layman's terms. 4. During an interview with the Clinical Manager (Admin) 3 on 02-12-2024 at 12:31 PM, they indicated they had never printed off and brought medication lists to the home.		their blue Acme folder and that it contains the patient'smost recent medication list. To ensurecorrection of this deficiency, the Alternate Clinical Director with theassistance of another agency RN, have contacted all primary care physicians andrequested updated medication lists for all patients. Upon receipt of said medication lists, theywill be uploaded into the electronic health record. Attending nurses will be required to takepaper copies to each patient visit and to review said list with the patientand/or authorized representative. A copyof the medication list will be left with the client and placed in their blueAcme folder. Nurses have been providedwith additional folders, should they visit a patient who no longer has thefolder in their possession. Nurses arebeing re-educated on the process of not only reviewing the medication listswith patients, but also on the reconciliation of medications within theelectronic health record, documenting any new medications, dischargedmedications and/or changes in medication dosage.	

			Upon completion of initial training program,Administrator and Executive Director will determine the second phase of there-education and training program to ascertain if weekly trainings are stillnecessary, or if the frequency of the trainings may be reduced. Patient care is the top priority, and ifnurse performance, through the review of newly performed assessments, plans ofcare and quality assurance home visits indicates that deficiencies in thisprocess still exist, trainings will continue on a weekly basis. The Clinical Manager and Alternate Clinical Manager will be responsiblefor ensuring that the agency is compliance with patient medication schedulesand instructions. In addition to thereview by the Clinical Manager and the Alternate Clinical Manager, theExecutive Director and the Social Worker will conduct quality assurance home visitsto ensure compliance in this area. Tofurther ensure said plan of correction is followed, the Executive Director andSocial Worker, collectively, will visit at least five clients per month	

			deficientpractice had the potential to affect all patients and the Clinical Manager hasthe ultimate responsibility to ensure that this plan of correction isfollowed. This plan of correction will remain ongoing innature and compliance threshold is 100%.	
G0640	Quality assessment/performance improvement 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Based on record review and interview, the agency failed to ensure they implemented, documented, and maintained an	G0640	A QAPI plan policyand binder was provided to surveyors and was found to be deficient incontent. The agency was very transparentin sharing that it has been a challenge to obtain numbers-driven data, but thatthe agency does conduct various quality assurance tasks and associatedimprovement actions. The agencyrecognizes that the plan has lacked measurable improvements and will work toensure that said improvements, as well as outcomes, are incorporated into theQAPI program. The Executive Director andClinical Manager have received additional training on the QAPI process and willcontinue to receive additional training through available resources. The knowledge gained through	2024-03-12

	effective, ongoing data-driven Quality Assessment and Performance Improvement (QAPI) program, involved all agency services, utilized quality indicators data, included data from OASIS data, failed to focus on high risk, high volume, or problem-prone areas including the use of emergent care, services, admissions, re-admission, considered incidence, and severity of problems in those areas, take immediate corrective actions identified that could directly or potentially threaten the health and safety of patients; failed to ensure the performance improvement projects analyzed their root cause and implemented appropriate actions and tracked the performance to ensure improvements are achieved; failed to ensure they conducted an annual performance improvement projects to ensure measurable progress had been achieved; and the Governing Body failed to ensure the QAPI program reflected the complexity of its organization and services in the their quality improvement program; failed to document QAPI activities including reasons		training andother available resources will be shared with other leadership members tofurther ensure that all leaders are involved in the QAPI process. All agencyleadership members will meet monthly and conduct QAPI meetings and appropriatedocumentation will be available in the QAPI program binder. In addition to the monthly multi-disciplinaryQAPI meetings, the Administrator, Executive Director and Clinical Manager will holda separate meeting of the triangle of leadership and further review the QAPIprogram to ensure that this plan of correction is being followed. This deficient practice had the potential toaffect all patients. The Administratorhas the ultimate responsibility for ensuring this correction. The threshold for compliance is 100% and thisplan of correction will remain ongoing in nature.	

	for Performance Improvement Projects and progress achieved on these projects.; failed to measure, analyze, and track, their monitoring of infections, incidents, and adverse events; failed to keep current and monitoring of their required quality measure; submit reports in mandated format within required timeframes per agency policy; failed to set clear expectations for patient safety: failed to complete self-assessment of the agency organization performance per agency policy; and failed to set clear expectations for patient safety; and that any findings of fraud or waste are addressed. The lack of an effective QAPI program impacts all 54 patients receiving services. The cumulative effect of these systemic problems resulted in the agency's ability to ensure patients received appropriate services which could result in the agency not providing quality health care for Condition of Participation of 42 CFR 484.65 Quality Assessment Performance Improvement. 1. An agency policy with a			

	revision date of April 2017, titled " Improving Organizational Performance" indicated but was not limited to, "Purpose: To establish patient outcomes as the primary focus of the organization's performance improvement activities. To improve organizational performance by focusing on high-risk, high volume, and problem-prone areas ... Performance improvement results will be utilized to address problem issues, improve the quality of care and patient safety, and will be incorporated into a program planning and process design and modifications ... The governing Body is responsible for ensuring that the performance improvement program is defined, implemented, maintained, and evaluated annually ... Identify and set specific outcomes for measurable improvement and acceptable limits for findings. 1. At least one important aspect related to care must be monitored through the use of OASIS data ... function or service care must be monitored ....Patient satisfaction surveys will be monitored ... Measuring current performance			

	against past performance ...The organization must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects ... Assure each performance improvement activity contains the following elements: 1. Descriptive indicator (s)/activities to be conducted 2. Frequency of activities 3. Designation of responsible party 4. Method(s) of data collection 5 Acceptable limits for findings ... 7. Follow-up plans ... Trends identified through performance improvement measurement and analysis will be reported to the Governing Body on a quarterly basis, 5. Results of performance improvement activities will be communicated with all staff via intranet, newsletters, email, etc ... " 2. On 02-12-2024 at 1:51 PM, the Executive Director, Admin 2, provided a folder containing the agency's QAPI. The folder contained an agency document titled, "QAPI Scheduled Items for Review Tracker 2023/2024" with a revision date of			

	2-11-2024. The folder contained an agency document titled, " Quality Assessment and Performance Improvement (QAPI) Plan" from the agency's policy and procedure book. During an interview on 02-12-2024 at 1:46 PM, Admin 2, confirmed they had completed the revised schedule tracker document over the weekend. Admin 2 further indicated they just did not have time to do an outcome-based QAPI. Admin 2 had no data to show measurable improvements, data collection of patient safety, or health outcomes related to quality of care. 3. On 02-12-2024 at 2:02 PM, Admin 2, provided agency documents titled, "QAPI Planning Meeting Outcomes and Follow Up" dated October 2, 2023, and September 1, 2023. The documents failed to indicate who was at the meetings, and the time of the meetings, and failed to address patient outcomes, trends, and plans. During an interview on			

	2, indicated the agency had no performance improvement projects (PIP) and could provide no further documents regarding the agency's QAPI program. 4. On 02-12-2024 at 5:25 PM-6:08 PM, the findings were reviewed with the Administrator, Admin 2, and the Clinical Manager, in which they had no further information or documentation to provide.			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the Case Manager failed to ensure the home health aide care plan was completed, individualized, and patient-specific for 1 of 3 active patient records reviewed. (Patient: #3) Findings Include: 1. An agency policy with a	G0798	. The agency has launched anextensive nurse training program in which nurses and leadership are meeting ona weekly basis so that nurses, including Clinical Manager and AlternateClinical Manager, can be in-serviced and re-trained on all processes, includinghome health aide assignments and duties. Nurses are being re-trained both individually and in group sessions,regarding home health aide assignments and duties. It is agency policy that an aide care plan becompleted upon each start of care, regardless of the service being provided,attendant care via Medicaid Waiver program or	2024-03-06

	revision date of October 2016, titled "Home Health Aide Plan of Care" indicated, " ... The patient's Case Manager, upon initialization of aide services, will develop the home health aide plan of care ... The home health aide plan of care will be individualized to the specific patient ... The Case Manager will review the home health aide plan of care with the aide assigned to the case ... " 2. A review of the clinical record for Patient #3, contained a plan of care for the recertification period from 01-30-2024 to 03-29-2024, electronically signed by the Registered Nurse (RN) 3, dated 01-25-2024. The plan of care indicated but was not limited to in the section titled "Orders for Disciplines and Treatments" orders for Attendant (ATTC) 65-69 hours weekly for 1 certification period and Home Health Aide (HHA) 91 hours weekly for 1 certification period. The plan of care failed to evidence treatments, problems, or interventions to be completed by the HHA. During an interview on 02-12-2024 at 10:45 AM, Patient		home health aide via MedicaidPrior Authorization. Nurses havereceived additional training on the various services types and associated payersources, with emphasis on differences between attendant care and home healthaide. Nurses have also been re-educatedon the responsibility of the attending nurse is to review the attendant careand/or home health aide care plan during each visit and make any updates asappropriate. Upon completion of initialtraining program, Administrator and Executive Director will determine thesecond phase of the re-education and training program to ascertain if weeklytrainings are still necessary, or if the frequency of the trainings may bereduced. Patient care is the toppriority, and if nurse performance, through the review of aide care plansindicates that deficiencies in this process still exist, trainings willcontinue on a weekly basis. To furtherensure the correction of this deficiency, the Executive Director and ClinicalManager have audited the records of all patients who have an attendantcaregiver	

	#3, indicated they did not want to be interviewed and hung up. 3. During an interview on 02-12-2024 at 4:47 PM, when queried about the HHA care being provided to Patient #3, RN 3 indicated they were unaware of the home health aide being assigned to provide care to Patient #3. RN 3 further indicated they were only aware of the Attendant providing care. 4. During an interview on 02-12-2024 at 5:08 PM the Clinical Manager confirmed Patient #3's clinical record had no HHA plan of care. When queried about how the HHA knew the patient care needs the Clinical Manager indicated the HHA must be that good of a HHA and knew what to do. 410 IAC 17-13-2(a) 410 IAC 17-14-1(m)		and/or home health aide. Anynoted deficiencies to care plans have been corrected. The Clinical Manager and Alternate ClinicalManager will be responsible for ensuring that the agency is in compliance withpatient home health aide assignments and duties. This deficient practice had the potential toaffect all patients and the Clinical manager has the ultimate responsibility toensure that this plan of correction is followed. In addition to the review by the ClinicalManager and the Alternate Clinical Manager, the Executive Director and Administratorwill conduct monthly quality assurance reviews of no less than 10% of theattendant caregiver and home health aide care plans. Thisplan of correction will remain ongoing in nature and compliance threshold is100%.	
G0940	Organization and administration of services 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain	G0940	The Administrator is onsite andmaintains daily presence at the agency and is actively involved in the day-to-dayoperations of the agency. TheAdministrator has two direct reports, the Executive Director and ClinicalManager,	2024-03-01

	the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. Based on record review and interview, the agency failed to ensure the Administrator was managing the day to day operations of the agency (see G948); failed to ensure the Clinical Manager had a signed job description and was aware of their position as Alternate Administrator (see G954); failed to ensure care was coordinated with other providers in the patient's home and the plan of care was updated, completed, and patient-specific (see G962); and failed to ensure the patient's needs were assessed as needed through comprehensive assessments (see G966). The cumulative effect of these problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR 484.105		who are both also involved in the overall day-to-day management andleadership of the agency. This plan ofcorrection has provided a plan of correction for the tags of G0948, G0954,G0962 and G0966 which are cited under this tag of G0940. The bulk of this plan of correction, not justfor this tag and the above referenced tags, involves the re-education andtraining of the nursing team, in particular the Clinical Manager who is to beleading the team. As cited previously,there is an impending change in the position of Clinical Manager. All of the plans of corrections for the abovereferenced deficiencies had the potential to affect all patients. The Executive Director and Administrator willcontinue to monitor no less than 10% of patient records on a monthly basis toensure that this plan of correction is being followed and implemented by allnursing team members. The Administrator hasthe responsibility of ensuring compliance in this area and the threshold forcompliance is 100%.	

	Organization and Administration of Services. *			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the Administrator failed to ensure they were responsible for day-to-day operations, had a data-driven Quality Assessment and Performance Improvement (QAPI) program, a current Emergency Preparedness plan reviewed, and a tabletop exercise at least annually, ensured public information was accurate regarding the services they provided, and trained the Alternate Administrator according to the job description for 1 of 1 home health agency. Findings Include: 1. An agency policy revised October 2016 titled "Organizational Planning" indicated but was not limited to,	G0948	The Administrator is onsiteand maintains daily presence at the agency and is actively involved in the day-to-dayoperations of the agency. TheAdministrator has two direct reports, the Executive Director and ClinicalManager, who are both also involved in the overall day-to-day management andleadership of the agency. Regardingfindings #1 and #2, as related to QAPI and referenced in the agency's plan ofcorrection for G0640, a QAPI plan policy and binder was provided to surveyorsand was found to be deficient in content. The agency was very transparent in sharing that it has been a challengeto obtain numbers-driven data, but that the agency does conduct various qualityassurance tasks and associated improvement plans. The agency recognizes that the plan haslacked measurable improvements and will work to ensure that said improvements,as well as outcomes, are incorporated into	2024-03-12

	responsible for developing and implementing an effective organization wide planning process ... 2. Clearly defining long-range, strategic, and operational plans ... The planning process includes: 1. the needs of individuals served, personnel, internal and external resources ... 4. Resources needed to provide and support care and services. 5. Recruitment, retention, development, and continuing education needs for all personnel. 6. The data needed to measure the performance of the processes and outcomes of care and services. 7. Results of organization quality assessment performance improvement activities ..."		the QAPI program. The Executive Director and Clinical Managerhave received additional training on the QAPI process and will continue toreceive additional training through available resources. The knowledge gained through training andother available resources will be shared with other leadership members tofurther ensure that all leaders are involved in the QAPI process. All agencyleadership members will meet monthly and conduct QAPI meetings and appropriatedocumentation will be available in the QAPI program binder. In addition to the monthly multi-disciplinaryQAPI meetings, the Administrator, Executive Director and Clinical Manager will holda separate meeting of the triangle of leadership and further review the QAPIprogram to ensure that this plan of correction is being followed. The Administrator has the ultimateresponsibility for ensuring this correction and the threshold for compliance is100%. Regarding finding #3, as relatedto the Emergency Preparedness Plan and binder and as referenced in the agency'splan of correction for	

	2. On 02-12-2024 at 1:51 PM, the Executive Director, Admin 2, provided a folder containing the agency's QAPI. The folder contained an agency document titled, "QAPI Scheduled Items for Review Tracker 2023/2024" with a revision date of 2-11-2024. The folder contained an agency document titled, " Quality Assessment and Performance Improvement (QAPI) Plan" from the agency's policy and procedure book. During an interview on 02-12-2024 at 1:46 PM, Admin 2, confirmed they had completed the revised schedule tracker document over the weekend. Admin 2 further indicated they just did not have time to do an outcome-based QAPI. Admin 2 had no data to show measurable improvements, data collection of patient safety, or health outcomes related to quality of care. 3. A review of the Emergency Preparedness binder evidenced an undated document titled "Hazard Vulnerability Analysis Worksheet". A document titled "Emergency Preparedness" dated 10-20-2023 evidenced		G0001, the agency does have an Emergency PreparednessProgram which involves both office staff as well as front line team members. The last quarterly emergency preparednessreview by office team members occurred in October, 2023, and the frontline teammembers have been scheduled for an emergency preparedness tabletop activity onMarch 12, 2024. Agency does recognizethat many of the documents in the Emergency Preparedness Binder, such as thelocal contact listing and district map for District 5 and other areas served,were outdated and were updated during the survey process. The agency's plan of correction has included,but not been limited to, updating emergency contact listings; updating internalemergency phone tree which is the pyramid phone communication plan; updatingagency's Hazard Vulnerability Analysis Worksheet, as well as hazardvulnerability planning priorities table; and updating command structure. In addition to these updates, the agency hasalso updated emergency preparedness in-service and	

	the agency reviewed education regarding active shooter, tornado, flood, civil unrest, and emergency shelter. There was no evidence an active drill or tabletop exercise was ever completed. There was no evidence the agency's emergency preparedness plan was reviewed annually or as needed. During an interview with Admin 2 on 02-12-2024 at 5:09 PM, they indicated they had no Emergency Preparedness program and were working on it. They indicated the date April 2017 on the Emergency Preparedness policy was most likely the last time the policy was reviewed and revised. They indicated they had not performed a tabletop exercise and had not collaborated with local, state, and federal officials. 4. On the agency's website, agency vehicle, and the Admission packet, it was evidenced the agency offered Skilled Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Work, and Companion services.		training materials whichwill be used for quarterly in-services and trainings. To further ensure compliance, the agency hasre-joined the Indiana District 5 Healthcare Coalition and has appointed theagency's Human Resource Director as the agency point of contact for coalitioncontact and communication. Additionally,the agency has entered into a memorandum of understanding with another localhome health provider which will serve as an agreement that will allow bothagencies the ability to support and assist one another in the event of anemergent event or disaster in our geographical service areas. The Human Resource Director will beresponsible for ensuring that the content within the emergency preparednessbinder is kept current and up-to-date, and for further ensuring that quarterly in-servicesand annual tabletop activities are scheduled and held. This deficiency had the potential to affectall patients and the Administrator is responsible for ensuring that this planof correction is followed. The ExecutiveDirector and Administrator will review	

	During an interview with Admin 2 on 02-08-2024 at 8:50 AM, they indicated they had no Medicare or therapy patients or therapists since August of 2022. 5. During an interview with the Clinical Manager (Admin 3) on 02-09-2024 at 1:36 PM, they indicated they were unaware they were the Alternate Administrator until they just saw the state letter. They indicated they had no training as the Alternate Administrator. 6. The Administrator failed to ensure marketing materials represented the actual therapies and services provided by the agency as evidenced by the Executive Director (Admin 2). Admin 2 indicated, on 02-09-2024 at 12:45 PM, they no longer offered Physical Therapy, Occupational Therapy, and Speech Therapy. 410 IAC 17-12-1(c)(1)		the emergency preparedness plan on amonthly basis to further monitor this plan of correction which will remainongoing in nature and the compliance threshold is 100%. Regarding findings #4 and #6, as related totherapy services, it is not the agency's intention to cease providing therapyservices. Rather, the current marketconditions and shortage of therapists has made it very difficult for thisagency, as well as many other agencies, to hire and retain qualitytherapists. As referenced in the agency'splan of correction for N0447, upon surveyprocess, management advised surveyor(s) that one physical therapist had been onmaternity leave and was being placed back into active status with the agencyand will be able to accept patients. Management also advised of a second physical therapist who is in thehiring process. The agency continues torecruit for occupational and speech therapists and has also spoken with otherhome health agencies and therapy providers in effort to contract with them foroccupational and speech therapy services. Agencies	

			approached vocalize they also have shortage in therapists andhave not been able to assist. The agencywill continue to diligently recruit for physical, occupational and speechtherapists. During the month ofFebruary, the agency has reached out to all previously employed therapists, whoare re-hirable, and have offered additional incentive for employment. Theagency recognizes this shortage has the potential to affect all patients andhas implemented other recruiting measures to include sign on bonus, outreachcalls to universities with graduating therapists, job fairs and additionalonline advertisement. Recruiting statuswill be discussed at leadership and quality improvement meetings, at leastweekly, to ensure that this deficiency remains a top priority. The Human Resource Director and theAdministrator have the responsibility of ensuring compliance is maintained inthis area and the threshold is 100% compliance. This plan of correction will remain ongoing in nature.	
G0954	Ensures qualified pre-designated person	G0954	The agency Administrator has	2024-03-01

	484.105(b)(2) When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section. Based on record review and interview, the agency failed to ensure the Alternate Administrator, was aware of their role as the Alternate Administrator and had a signed job description for the position of 1 of 1 Alternate Administrator. (Clinical Manager (Admin) 3) Findings Include: 1. An ACHC Home Health Human resources policy, revised October 2016, titled "Job Descriptions", Policy No. 1-011.1 indicated but was not limited to, " ... Procedure ... 2. ... each individual will receive and sign a job description specific to his/her position. ..." 2. During a review of the Governing body meeting minutes binder, it evidenced Admin 3 was appointed and approved as the Alternate Administrator. The document		metwith Alternate Administrator and a job description for this position has beensigned and added to the Clinical Manager/Alternate Administrator's employeefile. The agency employs an ExecutiveDirector who is also a direct report to the Administrator and who also serves asa primary leader within the agency and provides additional support to theAlternate Administrator. As an integralpart of this plan of correction, it is to be noted that there is an impendingchange in the role of Clinical Manager who also serves as the AlternateAdministrator. Therefore, the agency istransparent that the training of the current Clinical Manager for the role ofAlternate Administrator will remain limited, as it will be more beneficial tothe agency, employees and most importantly, the patients, for quality trainingtime to be spent with the individual who assumes this role. The agency will promptly notify the IndianaDepartment of Health when a change in the above position(s) occurs, as again,this change is impending at the time	

	dated 03-14-2023 was signed by the Board of Directors and failed to evidence Admin 3's signature. 3. During a review of Admin 3's employee file, it failed to evidence a job description for the position of the Alternate Administrator. Admin 3's employee file evidenced a letter from the state, and it indicated Admin 3 was the Alternate Administrator. 4. During an interview with Admin 3 on 02-09-2024 at 1:36 PM, they indicated they were unaware they were the Alternate Administrator until they saw the state letter. Admin 3 indicated they had never received training for the Alternate Administrator position. 410 IAC 17-12-1(d)(8)		this plan of correction is written. This Administrator is responsible forensuring this plan of correction is followed and the threshold for complianceis 100%.	
G0962	Coordinate patient care 484.105(c)(2) Coordinating patient care, Based on record review and interview, the Clinical Manager	G0962	The agency has launched anextensive nurse training program in which all nurses and leadership are meetingon a weekly basis so that nurses, including Clinical Manager and AlternateClinical Manager, can be in-serviced and re-trained on	2024-03-01

	failed to ensure the coordination of care with other providers in the patient's home for 1 of 1 home health agency. Findings Include: 1. The Clinical Manager's job description titled "Clinical Director" and dated 03-21-2023 indicated but was not limited to, " ... 1. Coordinates and oversees all direct and indirect patient services provided by clinical organization personnel ... 4. Provides help in assessment, planning, implementation and evaluation of patient and family/caregiver care to all clinical personnel as indicated ..." 2. A review of 4 of 6 active clinical records (Patients 2, 5, and 6), failed to evidence any coordination of care notes with the other providers providing care for the patients. The agency failed to coordinate care with Patient #2's adult day care facility, Entity 3. The agency failed to coordinate care with Patient #5's case manager with an adult social services agency, Entity 1, and the patient's personal services		the process ofcomprehensive assessments, care planning, the integration of all services andthe coordination of patient care delivery. The Clinical Manager is present for all of these trainings. The agency has taken further correctiveaction by also providing one-on-one additional training with the ClinicalManager to ensure that Clinical Manager has an understanding of the carecoordination process and the associated standards of documentation. The Clinical Manager has been re-trained onplans of care to include, but not be limited to, the prompt updating of plansof care; ensuring that plans of care are patient-specific; ensuring that plansof care contain all pertinent diagnosis, as well as patient’s mental,psychosocial and cognitive status; ensuring that plans of care contain types ofservices provided along with the frequency and duration of visits; ensuringthat plans of care include all durable medical equipment; ensuring plans ofcare include prognosis, rehabilitation potential, functional limitations and activitiespermitted; ensuring plans of care include nutritional	

	agency, Entity 12. The agency failed to coordinate care with Patient #6's incenter dialysis treatment facility, Entity 8. 3. During interviews with the Executive Director on 02-12-2024 at 11:45 AM, they indicated if the coordination of care notes were not in the charts, then they had no coordinated care with Entity 1, Entity 3, Entity 8, and Entity 12. 4. During a review of 6 of 6 active clinical records (Patients #1, 2, 3, 4, 5, and 6) and 6 of 6 focused audits of active clinical records (Patients #9, 10, 11, 12, 13, and 14), the Clinical Manager failed to ensure plans of care were updated, complete, patient-specific, and contained all pertinent diagnosis, patient's mental, psychosocial, and cognitive status, types of services, durable medical equipment (DME), frequency and duration of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all medications and treatments, safety		requirements, allmedications and treatments; ensuring plans of care include safety measures andrisk for hospitalization; ensuring plans of care include patient and caregivereducation and training, as well as interventions and advanced directives. The Executive Director and Administrator willcontinue to provide support and training to Clinical Manager. It is to be noted that this plan ofcorrection is written with an impending change in the role of Clinical Manager. This deficient practice had the potential toaffect all patients and the Administrator has the ultimate responsibility toensure that this plan of correction is followed. To further ensure said plan of correction,the Administrator and Executive will perform monthly quality assurance checkson no less than 10% of patient records. This plan of correction will remain ongoing in nature and compliancethreshold is 100%.	

	hospitalization, patient and caregiver education and training, interventions, and advanced directives. 5. During an interview with the Clinical Manager (Admin 3) on 02-09-2024 at 12:45 PM, they indicated the plans of care needed to be patient-specific and individualized.			
G0966	Assure patient needs are continually assessed 484.105(c)(4) Assuring that patient needs are continually assessed, and Based on record review and interview, the Clinical Manager failed to ensure needs were continuously assessed for 6 of 6 active clinical records (Patients: #1, 2, 3, 4, 5, and 6) and 6 of 6 focused clinical records reviewed (Patients: #9, 10, 11, 12, 13, and 14) and 2 of 2 closed records reviewed. (Patients: #7, and 8) Findings Include: 1. The Clinical Manager's job description titled "Clinical Director" and dated 03-21-2023 indicated but was not limited to, " ... The clinical manager is responsible for the overall	G0966	The agency has launched anextensive nurse training program in which all nurses and leadership are meetingon a weekly basis so that nurses, including Clinical Manager and AlternateClinical Manager, can be in-serviced and re-trained on the process ofcomprehensive assessments, care planning, the integration of all services andthe coordination of patient care delivery, as well as ongoing patientassessment. The Clinical Manager is presentfor all of these trainings. The agencyhas taken further corrective action by also providing one-on-one additionaltraining with the Clinical Manager to ensure that Clinical Manager has anunderstanding of the requirement that patient needs are being continuallyassessed.	2024-03-01

	direction of home health services ... 1. Coordinates and oversees all direct and indirect patient services provided by clinical organization personnel ... 4. Provides help in assessment, planning, implementation and evaluation of patient and family/caregiver care to all clinical personnel as indicated ..." 2. The Clinical Manager failed to ensure the comprehensive assessments and plan of cares of Patients #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14 were complete, timely, reflected the patient's current health, history and status, failed to ensure each patient's strengths, goals, and care preferences were included, failed to ensure each assessment included the patient's medical, nursing, rehabilitation, social, and discharge planning needs, failed to ensure coordination of care with the interdisciplinary team and outside agencies to ensure the patients' needs were met, failed to ensure each assessment identified the patient's caregiver, support, availability and schedule, willingness to provide care, failed to ensure the patients'		The Clinical Manager has beenre-trained on comprehensive assessments as well as the need for continualpatient assessment to include, but not be limited to, patient's current andprior health history, patient's strengths, goals and care preferences; patient'smedical, nursing, rehabilitation, social and discharge planning needs;coordination of care with the interdisciplinary team and outside agencies toensure patient needs are met; identification of patient caregivers, support,availability and schedule, as well as willingness to provide care; informing relevantphysicians of changes in patient condition and services being provided. training of nursing staff regardingdocumentation process for the plan of care elements and comprehensiveassessments. It is to be noted that thisplan of correction is written with an impending change in the role of Clinical Manager. This deficient practice had the potential toaffect all patients and the Administrator has the ultimate responsibility toensure that this plan of correction is followed.	

	physicians were informed of changes in condition and services being provided, and failed to ensure the training of nursing staff regarding the documentation process for the plan of care elements, and comprehensive assessments. During an interview on 02-07-2024 at 1:11 PM, the Executive Director, Admin 2 indicated the Clinical Manager required a lot of guidance in their job.		To further ensure said plan of correction,the Administrator and Executive will perform monthly quality assurance checkson no less than 10% of patient records. This plan of correction will remain ongoing in nature and compliancethreshold is 100%.	
G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. Based on record review and interview, the agency failed to ensure a discharge and transfer	G1022	Upon notification of thisdeficiency, the Clinical Manager finalized discharge assessment for Patient #7and notified physician of discharge. RegardingPatient #8, upon notification of deficiency, the Clinical Manager sent therelevant physician notification of discharge and physician order ofdischarge. Clinical Manager has sincecompleted discharge summary and sent to relevant physician. Agency leadership has audited all dischargesdating back to 2/1/2023 to determine if other deficiencies existed in thisarea. All identified deficiencies havebeen corrected	2024-03-01

	summary was written and sent to the primary care provider who is responsible for the patient's care after discharge within 72 hours of discharge (Patient: #7) and within 48 hours of transfer to another facility (Patient: #8) for 2 of 2 discharged records reviewed. Findings Include: 1. An agency policy with a revision date of October 2016, titled "Discharge Summary" indicated but was not limited to, " ... The discharge summary and other relevant clinical record documents will be completed and submitted within 72 hours of discharge from service ... " 2. An agency policy with a revision date of October 2016, titled "Transfer Summary" indicated but was not limited to, " ... Within 48 hours of transfer, the transferring clinician will complete a transfer summary ... " 3. A review of the inactive clinical record for Patient #7, on 02-08-2024, with a discharge date of 10-20-2023, failed to contain a discharge summary. During an interview on 02-12-2024 at 9:02 AM, the		and relevant physicians notified. Agency leadership has re-educated nurses onthe requirement to follow agency policy and complete a comprehensive dischargeassessment and within 72 hours from discharge or to complete a transfer summarywithin 48 hours of transfer if patient is being or has been transferred toanother facility. Leadership has furthereducated Clinical Manager and Alternate Clinical Manager of his/herresponsibility to review said discharge documentation and perform qualityassurance to ensure that it is completed timely within the electronic healthrecord. Clinical Manager and AlternateClinical Manager have been re-educated and trained on their responsibility toensure that all pertinent documents, discharge summary, assessment andmedication list are sent to the relevant physician(s), receiving facility (whenapplicable) and other appropriate multi-disciplinary members. To ensure that this deficient practice doesnot again occur, the Clinical Manager and/or Alternate Clinical Manager willprovide updates	

	Clinical Manager indicated they were completing the discharge assessment, summary, and order. 4. A review of the inactive clinical record for Patient #8, on 02-08-2024, with a transfer discharge date of 10-25-2023, contained a signed physician order dated 10-29-2023, signed by the Clinical Manager. The order indicated Patient #8 had missed their recertification due to an unplanned hospitalization and was being discharged. The record failed to evidence a transfer discharge summary was completed and sent to the primary care provider. During an interview on 02-12-2024 at 8:30 AM, the Intake/Medical Records Coordinator, Admin 6, indicated Patient #8's record did not contain a transfer/discharge summary. 5. A review of agency documents, an agency letter dated 02-12-2024, and a fax confirmation, addressed to Patient #8's physician. The letter indicated the agency discovered during a chart audit that they		during daily leadership meetings and quality improvementmeetings. The Administrator andExecutive Director will perform monthly audits on no less than 10% of patientdischarge records to ensure that nurses and nurse leadership are following thisplan of correction. The threshold forcompliance is 100% and this plan of correction will remain ongoing in nature.	

	of Patient #8's transfer and discharge and were sending them the required documents today. 410 IAC 17-15-1(a)(6)			
N0000	Initial Comments This visit was for a State Re-licensure survey of a Home Health Agency. Survey Dates: 02-07-2024 to 02-12-2024 Census: 54 Unduplicated Skilled Admissions: 2 QR completed by Area 3 on 2/20/2024.	N0000		
N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be:	N0440	TheSocial Worker does not have direct reports. During survey process, it was brought to attention of administrationthat the design of the organizational chart could be read to indicate thatfront-line caregivers report to the Social Worker. It was also brought to attention that	2024-03-01

	(1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the agency administration and management failed to clearly identify the line of authority for the delegation of responsibility down to the patient level on their organization chart for 1 of 1 agency. Findings Include: 1. An agency policy with a revision date of October 2016, titled "Use of Organization Chart" indicated but was not limited to, "Purpose: To facilitate effective overall management and administration of the organization and establish communication channels for all organization personnel…. " 2. A review of an agency document updated December 2023, titled "Organizational Chart" indicated a line of authority from the Social Worker to the Field Staff, which included the following under Field Staff: Home Health		theorganizational chart should not only have roles, but also the names of keyleadership team members. Theorganizational chart was revised to align the Clinical Manager's delegation ofauthority over the clinical staff, as well as the addition of the personalnames of those with key leadership roles. The revised organizational chart was provided to IDOH representative(s)during the survey process. Agency HumanResource Director has provided revised organizational chart to all employees,with explanation of the revisions, and employees have signed to validate thatthe revisions have been reviewed with them. Upon agency receiving Statement of Deficiencies, it is noted thatorganizational chart is to set delegation down to the patient level. The organizational chart has been revisedagain, during month of February 2024, to include delegation down to patientlevel and employees have signed for the updated chart. The Human Resource Director is responsible toensure that all current employees, as well as future employees, are providedwith and sign for the most recent revision of the	

	Home Health Aide-Attendant (ATTC), Home Health Aide-Respite, Home Health Aide-Home Care Assistance, Licensed Practical Nurse (LPN)/Registered Nurse (RN), LPN/RN-Respite, and LPN/RN-Integrated Health Care Coordination (IHCC). The organizational chart failed to set delegation down to the patient level and failed to align the Clinical Manager's delegation of authority over the clinical staff. During an interview on 02-07-2024 at 1:14 PM, when queried regarding the organizational chart lines of authority from the Social worker over the clinical staff, the Executive Director, Admin 2, indicated no clinical staff should report to the Social Worker. Admin 2 further indicated the clinical staff should report to the Clinical Manager.		organizational chart. The organizational chart will be reviewedmonthly, during leadership and quality improvement meetings, to ensure that italways reflects any changes in leadership members or newly hiredpositions. This plan of correction willremain ongoing in nature and the threshold for compliance is 100%.	
N0447	Home health agency administration/management 410 IAC 17-12-1(c)(4)	N0447	Uponsurvey process, management advised surveyor(s) that one physical therapist hadbeen on maternity leave and was being placed back into active work status withthe ability to accept patients. Management also	2024-03-12

	Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on observation and interview, the Administrator failed to ensure the services they provided were accurate for the public for 1 of 1 Home Health Agency. Findings Include: 1. During a review of the agency website on 02-01-2024 at 3:50 PM, it was evidenced the agency provided Skilled nursing, Physical therapy, Occupational therapy, Speech Therapy, Medical Social Worker, and Companionship. 2. For 4 of 4 days survey days, it was evidenced on the agency vehicle, the agency advertised they provided the services, "NURSES, THERAPISTS, AIDES, COMPANIONS, DOCTORS" 3. During a review of the Admission packet on 02-07-2024 at 9:34 AM, it evidenced they had the services;		advised of a second physical therapist who is in thehiring process. The agency continues torecruit all therapy disciplines (physical, occupational and speech) and has alsospoken with other home health agencies and therapy providers to contract withthem for occupational and speech therapy services. Agencies approached vocalize they also haveshortage in therapists and have not been able to assist. The agency will continue to diligentlyrecruit physical, occupational and speech therapists. During the month of February, the agency hasreached out to all previously employed therapists, who are re-hirable, and haveoffered additional incentive for employment. The agency is confident that thiseffort will result in the re-hiring of two occupational therapists. The agency recognizes this shortage has thepotential to affect all patients and has implemented other recruiting measuresto include sign on bonus, outreach calls to universities with graduatingtherapists, job fairs and additional online advertisement. Recruiting status will be discussed	

	Skilled nursing, Rehabilitation Therapy, Medical Social Services, Home Health Aides, and Companions. 4. During an interview with the Executive Director, Administrative staff (Admin) 2, on 02-07-2024 at 9:44 AM, they indicated they had no therapists at the time. 5. During an interview with Admin 2 on 02-08-2024 at 8:50 AM, they indicated they had no Medicare or therapy patients or therapists since August of 2022.		atleadership and quality improvement meetings, at least weekly, to ensure thatthis deficiency remains a top priority. TheHuman Resource Director and the Administrator have the responsibility ofensuring compliance is maintained in this area and the threshold is 100%compliance. This plan of correction willremain ongoing in nature.	
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2.	N0458	**T**heagency's Clinical Director performed an annual performance evaluation with RN 1on February 26, 2024. Agency HumanResource Director, Executive Director and Administrator reviewed all otheremployee files to ensure that performance evaluations were present for year2023. No other deficiencies were notedin this area. An updated system oftracking anniversary dates and performance reviews has been implemented toensure that there will be no further deficiencies. Annual performance evaluations will	2024-02-26

	(4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the agency failed to ensure an annual performance evaluation was performed on 1 of 3 Registered Nurses (RN) employee files reviewed. (RN 1) Findings Include: 1. A policy revised October 2016 and titled "Performance Evaluations", Policy No. 1-021.1, indicated but was not limited to, " ... Procedure, 1. Performance evaluations will be completed (and dated) on all personnel as follows: ... B. Annually, based on personnel's annual evaluation date ..." 2. During a review of the employee record for RN 1, hired 04-02-2021, the record failed to evidence any performance evaluations were completed. 3. During an interview with Human Resources/Scheduler on 02-12-2024 at 2:05 PM, they indicated if the employee had a performance evaluation, it was		bediscussed at monthly leadership and quality improvement meetings. The Human Resource Director has theresponsibility to remain diligent to ensure that the threshold of 100%compliance is achieved and maintained in this area. This plan of correction will remain ongoingin nature.	

	1's employee file had not contained any performance evaluations.			
N0466	Home health agency administration/management 410 IAC 17-12-1(j) Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on record review and interview, the agency failed to ensure employee medical records were in a separate file for 4 of 4 employee records reviewed. (Clinical Manager, Registered Nurse (RN) 1, RN 2, and Home Health Aide (HHA) 3) Findings Include: 1. During a review of the employee records, it was evidenced the agency failed to maintain a separate, confidential medical record file for the physical examinations and tuberculosis tests.	N0466	AgencyHuman Resource Director and Administrator have removed all physicalexaminations and tuberculosis evaluations, as well as clinical follow-ups fromemployee files and have placed them into separate files labeled as"confidential employee medical records". Employee files will be audited by the Human Resource Director, ExecutiveDirector and Administrator at least quarterly to ensure that this deficientpractice does not again occur. Thethreshold for compliance is 100% and the Human Resource Director is responsiblefor ensuring compliance. This plan of correction will remain ongoing innature.	2024-02-18

	2. During an interview with Human Resources/Scheduler on 02-12-2024 at 2:05 PM, they indicated they were unaware the employee's medical information was to be kept separate from the rest of the employee file.			
N0468	Home health agency administration/management 410 IAC 17-12-1(k) and (l) Rule 12 Sec. 1(k) The following records shall be made available, on request, to the department for review: (1) Personnel records and policies that document the home health agency's compliance with subsection (f). (2) Records of physical examinations that document the agency's compliance with subsection (h). (3) Records of the following: (A) Tuberculosis evaluations. (B) Appropriate clinical follow-up for positive findings. (C) Any other records that document the home health agency's compliance with subsection (i). (l) The department shall: (1) treat the information described in subsection (k) as confidential medical records; and (2) use it only for the purposes for which it was obtained.	N0468	The agency's tuberculosis screening policy has beenupdated. The agency is in 100% complianceto ensure that all employees who have direct patient contact have been screenedfor Tuberculosis by one of the following methods: tuberculin skin testing via Mantouxplacement, QuantiFERON blood testing or chest x-ray. Said screening is performed upon hire andprior to first patient contact, as well as annually. Result of testing, along with due date fornext annual testing, are entered into the system's electronic record andemployees are automatically removed from the schedule if their annualtuberculin testing is not completed. Theagency was found to be deficient with the tuberculosis assessmentquestionnaire. Most employees have theirpre-employment and	2024-03-01

	Based on record review and interview, the agency failed to ensure 2 of 3 Registered Nurses (RN) employee files reviewed had annual tuberculosis questions. (Clinical Manager and RN 2) Findings Include: 1. During an interview with the Executive Director, Admin 2, on 02-12-2024 at 6:15 PM, they confirmed they were unable to provide a tuberculosis policy for employees. 2. During a review of the Clinical Manager's employee file, hired 09-01-2017, it failed to evidence a Tuberculosis assessment questionnaire was completed annually. The agency failed to evidence a Tuberculosis assessment questionnaire for the year 2023. 3. During a review of RN 2's employee file, hired 06-21-2017, it failed to evidence a Tuberculosis assessment questionnaire was completed annually. The agency failed to ensure a Tuberculosis assessment questionnaire was completed for the years 2021, 2022, and 2023. 4. During an interview with		annual tuberculosis screening performed at the agency officeby the Clinical Manager. The form thatis used by the agency includes employee consent to testing and annualassessment questionnaire, as well as documentation of placement of Mantoux andthe accompanying results of said placement. The Human Resource Director, Executive Director and Administrator havereviewed all employee medical records for 2023 and 2024 and have noted thatdeficiencies found were either with employees who had chest x-rays or who hadMantoux placement with their PCP or another provider. Those employees did not have the annualtuberculosis assessment questionnaire. To correct this deficient practice, a separate tuberculosis screening questionnaire has been createdand implemented for those employees who must have chest x-ray or who go toanother provider for tuberculosis testing. The Human Resource Director has corrected this deficient practice toensure that a current annual assessment questionnaire is now present for allemployees.	

	Admin 2 on 02-12-2024 at 12:31 PM, they indicated the annual tuberculosis questionnaires were not current. 5. During an interview with Human Resources/Scheduler on 02-12-2024 at 2:05 PM, they confirmed the tuberculosis annual questionnaires for the Clinical Manager and RN 2 were not current.		To ensure that the agency'scompliance threshold of 100% is met, this item will be reviewed at leastmonthly during leadership and quality improvement meetings; and complianceaudits will be completed at least annually. This plan of correction will remain ongoing in nature.	

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
Kamala M. West	Executive Director	3/1/2024 9:59:39 PM