STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157692	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elite Home Rehab And Healthcare Corp	580 EAST CARMEL DRIVE, SUITE 208, CARMEL, IN, 46032

(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
G0000	INITIAL COMMENTS This visit was for a Federal and State Complaint survey of a Deemed Home Health provider. Complaint 94479: Substantiated-. Federal and State Deficiencies were cited. Survey Dates: 2/8/23. 2/9/23, 2/10/23 Unduplicated Census: 412 QA Area 4 2/20/2022	G0000	POC accepted 3-18-23 Deborah Franco, RN Type text here	2023-03-10
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as	G0544	The Administrator, Director of Nursing and staff have all been reoriented and re-educated regarding Guidelines for Assessment Policy 2.7 and Care Plan Policy 2.8 including but not limited to ensuring that the patient's current problems and	2023-03-10

	the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on observation, record review, and interview, the agency failed to ensure updates and revisions to the comprehensive assessment were made, including changes to the plan of care, when a patient experienced a change in condition in 1 of 5 clinical records reviewed. (Patient 5) Findings include: 1. Review of a 2018 dated agency document "2.7 GUIDELINES FOR ASSESSMENT" page 3 stated, "Reassessment... To ensure that the patient/client's current problems and needs are continually evaluated and the care provided is adjusted accordingly, the patient/client's status is reviewed periodically. The reassessment process is ongoing throughout the patient/client's contact with the Agency. Each patient/client is reassessed to determine the patient/client's response to care or services. Reassessment occurs: 1. When the patient/client's condition significantly changes. 2. When the patient/client's diagnosis		needs are continuously evaluated and the care provided is adjusted accordingly with reassessments occurring when the patient's condition significantly changes, the patient's diagnosis changes, within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason except diagnostic tests or on physician-orderd resumption date, and every 60 days when the patient is receiving skilled services. The staff understands to ensure that a patient's needs are being met adequately and appropriately and services are adapted and adjusted within an individual patient situation, the care plan is essential and shall be updated as often as the patient's condition indicates but at least every 60 days for skilled patients. These policies will continue to be reviewed at monthly staff meetings for the next 6 months. The Director of Nursing has reviewed the clinical record and care plan with the Case Manager for Patient 5 to make sure these policies are now being followed and corrected. The Director of Nursing will	

	changes...4. Within 48 hours of the patient's return home from a hospital admission of 24 hours or more for any reason except diagnostic tests or on physician-ordered resumption date. 5. Every 60 days when the patient/client is receiving skilled services."		audit 100% of Care Plans to ensure services are adapted and adjusted as needed and that care is being continuously evaluated with reassessments occurring appropriately until there is 100% compliance. Audits will be performed for a minimum of one month if the threshold is met sooner. Thereafter 10% of records will continue to be audited quarterly. The Director of Nursing with the Clinical Managers will audit 100% of wound care orders to ensure the care performed is what the physician ordered and the Care Plan is updated timely. These will continue to always be reviewed by the Director of Nursing or a Clinical Manager in addition to the Case Manager.	

	2. Review of a 2016 dated agency document "2.8 CARE PLAN" page 19 stated, "Development of Care Plan ... In order to ensure that a patient's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual patient situation as needed, a care plan is essential." "...Continuing evaluation and service modifications are provided as indicated as an integral part of the ongoing provision of Agency services ..." "The patient care plan shall be updated as often as the patient's condition indicates but at least every sixty (60) days for skilled patients." Page 21 stated, "11. Revision of the plan of care as frequently as necessary to reflect the changing care needs of the patient but no less frequently as every 60 days ..." 3. On 2/9/23 at 1:22 PM, during a home visit observation for wound care with Patient 5, RN 3 was observed providing wound care to the left leg and to three (3) separate abdominal sites. The nurse stated the patient’s abdominal wounds were related to a recent laparoscopic			

	procedure where the patient's kidney had been removed. 4. During a review of the clinical record for Patient 5, for the certification period of 1/16/23 through 3/16/23, evidenced a document titled "Home Health Certification and Plan of Care" dated 1/13/23. The document stated, "Principle Diagnosis...Type 2 diabetes mellitus with foot ulcer." The next section, titled "Surgical Procedure" was left blank. The following section titled '"Other Pertinent Diagnosis" contained the following diagnosis, "Non-pressure chronic ulcer of other part of right lower leg limited to breakdown of skin, Non-pressure ulcer of other part of left lower leg limited to breakdown of skin, Essential (primary) hypertension, anxiety disorder, unspecified, spinal stenosis, Hypothyroidism, hyperlipidemia, Long-term (current) use of oral hypoglycemic drugs, History of falling". The document failed to evidence any recent surgical procedures that had been performed during the last 60 days and failed to evidence the			

record had been updated with any new corresponding diagnoses.

During a review of the clinical record for Patient 5, a document dated 1/13/23, titled "OASIS Recertification" was reviewed. The document indicated Patient 5's Primary diagnoses as Type 2 diabetes with foot ulcer and other diagnoses included non-pressure chronic ulcers of multiple parts of the right lower leg limited to breakdown of skin, essential (primary) hypertension, anxiety disorder, unspecified, spinal stenosis, hypothyroidism, hyperlipidemia, long-term (current) use of oral hypoglycemic drugs, and a history of falling. Patient 5's pertinent history failed to include cancer, surgery, and prior hospitalizations. Page 18 stated further, "Patient Contact with Physician ... Physician: ['Physician H' typed in] ... Was the visit related to the primary reason for Home health? [box marked "Yes" was checked] ... Reason for visit: Wound care ... Date last visited: 11/08/2022. The Goals and Interventions Summary indicated the patient was referred to home health

	care for wound care. Wound care orders included "SN [Skilled Nurse] to perform wound care to left lower leg (upper wound)...left lower leg (lower wound) ... SN to perform wound care to left lower abdominal [area]. Cleanse wound with bleach solution soak for 10 minutes, rinse with NS (Normal Saline), apply xeroform (iodine-impregnated gauze), cover and secure with [bordered foam] dressing 3x3, using aseptic technique, to be changed by SN, 2 times per week ... SN to perform wound care to the left upper abdominal [area]. Cleanse wound with bleach solution soak for 10 minutes, rinse with NS, apply xeroform, cover and secure with [bordered foam] dressing 3x3, using aseptic technique, to be changed by SN, 2 times per week ... SN to perform wound care to midline upper abdominal [area]. Cleanse wound with bleach solution soak for 10 minutes, rinse with NS, apply xeroform, cover and secure with [bordered foam] dressing 3x3, using aseptic technique, to be changed by SN, 2 times per week ... SN to perform wound care to all abdominal surgery sites.			

Cleanse wound with hibicleanse [sic], apply Prisma, cover and secure with Allevyn 4x4, using aseptic technique, to be changed by SN, 2 times per week."

The document contained evidence of a recent surgical procedure not included in the clinical record, and evidenced conflicting wound care orders.

The clinical record failed to evidence agency documentation of a new corresponding diagnosis of malignant neoplasm of the left kidney and failed to evidence documentation of the patient's recent laparoscopic surgery for partial removal of the left kidney.

5. In an interview on 2/10/23 at 10:50 AM, RN C (with Entity B) indicated that Entity B has been providing wound care to Patient 5 related to the patient's laparoscopic surgery on 12/21/23 for a left partial nephrectomy, related to a malignant neoplasm of the left kidney, leaving the patient with several abdominal surgical sites. RN C indicated that after the patient's post-surgical visit with

	the surgeon on 1/16/23, Entity B was asked to be involved in the patient's abdominal wounds (Entity B had been caring for the leg wound as well at the time). RN C indicated further that Entity B had been faxing wound care orders on Patient 5's abdominal wounds to Elite Rehab weekly since 1/17/23. 6. On 2/10/23 at 11:18 AM, discussed concerns regarding conflicting wound care orders, care performed versus what the physician ordered, and orders that were not timely and therefore inaccurate, written by RN 3 for Patient 5, the Administrator offered no comment and no documentation to show compliance. IAC 410 17-14-1(a)(1)(B)			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on observation, record review, and interview, the agency failed to ensure	G0580	The Administrator, Director of Nursing and staff have all been reoriented and re-educated regarding the Condition of Participation Standard 484.60(b) including but not limited to ensuring all drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This policy will also continue to be discussed at monthly staff meetings for the next six months. The Director of Nursing has reviewed the clinical record and care plan with the Case Manager/RN for Patient 5 as well as has performed a supervisory visit on the RN to ensure the RN is performing treatments only	2023-03-10

	treatments or care were furnished in accordance with current physician orders in 1 of 5 home visits observed. (Patient 5) Findings include: 1. On 2/9/23 at 1:22 PM, during a home visit for Patient 5, RN (Registered Nurse) 3 was observed providing wound care to 4 separate sites (a left leg wound, and 3 abdominal wounds.) All sites were cleansed using gauze and normal saline. Hibiclens was not used during the observation. 2. On 2/9/23, reviewed a document "Change Orders" dated 2/06/23, for Patient 5. The document indicated the following, "SN (Skilled Nurse) to perform wound care to left lower leg. Cleanse wound with bleach solution 10-minute soak, Hibiclens, [rinse] with NS (normal saline), apply Prisma (wound dressing) with Silver (antimicrobial wound covering) to wound bed, cover with gauze and secure with [Kirlex] followed by ace wrap, using aseptic technique." 3. On 2/10/23 the		as ordered by a physician or allowed practitioner. The Director or Nursing will perform supervisory visits on all the nursing staff, RN and LPNs, until 100% compliance is met. Thereafter employees will continue to have supervisory visits done annually to ensure all are in compliance.	

	Administrator submitted an agency document dated, 2/9/23 titled "Change Orders" and indicated RN 3 had completed these orders after the home observation on 2/9/23. The orders stated, "Changed Interventions - Previous: SN to perform wound care to the left lower leg. Cleanse with bleach solution 10-minute soak, Hibiclense [sic], rince [sic] with NS, apply Prisma with Silver to wound bed, cover with gauze and secure with [Kirlex] followed by ace wrap, using aseptic technique ... Changed to: SN to perform wound care to left lower leg (upper wound). Cleanse wound with bleach solution 10 minute soak, Hibiclense [sic], [rinse] with NS, apply Xeroform, covered with [bordered] foam dressing, using aseptic technique." "Previous: SN to perform wound care to right foot. Apply Allevyn to newly healed wound for protection, using aseptic technique, to be changed by nurse 2 times per week...Changed to: SN to perform wound care to left lower leg (lower wound). Cleanse with bleach solution 10-minute soak, Hibiclense [sic], rince [sic] with NS, apply			

	Xeroform, cover with [bordered] foam dressing, using aseptic technique..." 410 IAC 17-13-1(a)			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review and interview the agency failed to ensure staff followed accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases in 2 of 3 home visits observed. (Patients 1 and 5) Findings include: 1. A review of an agency document "2.78 BAG TECHNIQUE" stated, "Policy: The Agency provides guidelines for	G0682	The Administrator, Director of Nursing, and all staff have all been reoriented and re-educated regarding Bag Technique Policy 2.78, Hand Washing Policy-In Patient's Home 2.79, and Standard Precautions for all Health Care Workers Policy 5.7 including but not limited to ensuring all staff shall utilize proper bag technique to maximize infection control and minimize potential for cross-contamination of infection microorganisms, utilize proper hand washing in the home to assure that every effort is made to reduce the risk of infection in patients and staff members, and utilize standard precautions for all patients receiving care. These policies will continue to be discussed at monthly staff meetings for the next 6 months. The Director of Nursing has performed supervisory visits on RN 2 and RN 3 to ensure they are both following these policies during wound care as well as during the entire visit with the patient. The Director of Nursing and Clinical Managers will perform supervisory visits on all clinical staff until 100% compliance for infection prevention is met. Thereafter employees will continue to have supervisory visits done annually to ensure all are in compliance.	2023-03-10

	equipment and supplies into the patient's home. It is the policy of this Agency that all staff shall utilize proper bag technique, following the agency procedure when conducting home visits... Purpose: To maximize infection control and minimize potential for cross-contamination of infectious microorganisms ... ALL FIELD STAFF ARE EXPECTED TO: 1. Select and prepare adequate workspace from which to use the bag. Since floors are considered to be highly contaminated, bags are never to be placed on the floor ... 5. The most effective form of infection control is good handwashing. Employees must cleanse hands before entering/removing supplies from the bag, before examination, and after patient care ... 7. If additional supplies are needed during the visit, hands are to be cleansed before re-entering the bag. Alcohol-based hand sanitizer gel may be used. Careful planning limits this occurrence..." 2. A review of an agency document "2.79 HAND WASHING POLICY - IN			

PATIENT'S HOMES" stated "Policy: It is the practice of this agency to assure that every effort is made to reduce the risk for infection in patients and staff members. Thorough hand washing/hand antisepsis is required for all employees. The agency has established guidelines for all staff and will provide education and direction on accepted practices. Purposes: To improve hand-hygiene practices of agency staff and reduce transmission of pathogenic microorganisms to patients and personnel in the home care setting. Special Instructions: a. 1. Use of alcohol-based hand sanitizer is preferred (until dry). If antimicrobial soap is used, it must be for a period of at least 15 seconds. (www.cdcgov/handhygiene/training/interactive Education). b. a. Before and after caring for patients, or when coming into contact with inanimate objects/equipment in the immediate vicinity of the patient ... Between tasks on the same patient ... After removing gloves ... After touching objects that are potentially contaminated ... When hands are visibly dirty/soiled or contaminated with

proteinaceous material or other body fluids soap and water should be used first. a. (1) An alcohol-based hand rub for routinely decontaminating hands in all other clinical situations are acceptable ... OTHER ASPECTS OF HAND HYGIENE ... 3. Gloves are to be worn during patient care when there is a risk of contact with blood or other potentially infectious materials, mucus membranes, and no-intact skin could occur."

3. A review of a 2016 dated agency document "5.7 STANDARD PRECAUTIONS FOR ALL HEALTHCARE WORKERS" stated, "1. Standard Precautions shall be observed by every health care worker for all patients receiving care ... 2. WASH HANDS - hands must be washed before and after contact with each patient under a steady stream of water with an appropriate antibacterial solution for at least 20 seconds. In the absence of water, an appropriate antibacterial solution must be used. 3. Gloves, such as vinyl or latex medical gloves, must be worn... including but not limited to the following: ... b. dressing

changes ...4. Gloves should be changed after each patient contact. When gloves are removed, thorough hand washing is required. Gloves do not take the place of hand washing."

4. On 2/9/23 at 10:25 AM, during a home observation for wound care with Patient 1, RN 2 was witnessed approaching the front door with a surgical mask secured around both ears, but sitting under the chin. The nurse, with a bare hand, raised the mask up to cover the nose and mouth before entering the home. Later in the visit, the nurse sanitized hands, donned gloves, and removed Kerlix (rolled gauze) and Coban (a self-adhering, light compression, rolled bandage) wrappings from both legs, which were in place from just below the knee, covering the foot, but ended just before the toes. (The left leg had an open weeping wound, and the right leg was without wounds). Using the same gloves the nurse proceeded to wash the right leg with an aqua-colored washcloth given to the nurse by the patient's family member and washed the leg with water from

a basin that was also provided by the family member. A family member in the room informed the nurse that the patient was scheduled to see a dermatologist soon, to figure out why the wound hasn't healed and stated "it has been about a year" that the patient has had the wound. When inquiring as to what else was in the water in the basin, it was discovered that there were no additives in the basin of water. The nurse then doffed gloves, grabbed a container of liquid soap, dispensed a few pumps of soap into the basin, sanitized both hands with hand sanitizer, donned new gloves, and proceeded to wash both legs with the soap and water. The same aqua-colored washcloth was used to wash both legs, and the basin of water was not changed out between the cleansing of each leg. The nurse then doffed gloves after cleansing both legs and reached for a package of 'Water Wipes', and used these wipes to remove soap residue from the legs, doffed gloves, retrieved a jar of Aquafor, sanitized hands, and donned new gloves. The nurse opened the jar of Aquafor, reached into the jar, and

applied Aquafor to the other gloved hand, this was then spread over the surface of both legs with both gloves. With the same gloves still on, an Unna boot (a calamine-infused rolled gauze) was applied to the left leg. With the same gloves still in place, both the left and right legs were re-wrapped with new kerlix, then new Coban. Later, while assessing vitals, the nurse, with the right bare hand, touched a smartwatch on their left wrist and then used the same right hand to assess the patient’s right radial pulse.

5. On 2/9/23 at 1:22 PM, during a home observation for wound care with Patient 5, RN 3 was observed providing wound care to 4 separate sites (one leg wound, and three abdominal wounds). The nurse stated the patient’s abdominal wounds were related to a recent laparoscopic procedure where the patient’s kidney was removed. Care was performed in a swivel chair that did not recline. The patient was in an upright seated position for the duration of the visit. The patient attempted to assist with the dressing change with bare

sweatshirt lifted up away from the lower abdomen, while also attempting to retract any loose abdominal skin from falling over onto the three (3) small abdominal surgical sites. Using gloved hands, the nurse removed all three abdominal dressings then placed individual pieces of gauze soaked with a bleach solution on all three abdominal sites, then left these to sit for an undetermined amount of time. The nurse then doffed gloves and failed to perform hand hygiene. The nurse donned new gloves, then picked up a few stapled pages of new orders from the wound clinic, reviewed them, then set the papers back down. Using the same gloves, the nurse removed a dressing on the medial aspect of the left lower leg and placed another bleach-soaked gauze on the leg wound to stay in place for a time. While wounds were soaking, the patient was no longer retracting skin over the sites. The nurse then doffed gloves and failed to perform hand hygiene. While crouched down near the patient, the nurse became aware his/her pink surgical mask had slipped down below the tip of the nose.

The nurse reached up with the right bare hand and adjusted the mask back up over the nose. Hands were not sanitized. New gloves were donned, and the nurse proceeded to wipe down vital sign equipment with sanitizing wipes, then doffed gloves. The nurse failed to perform hand hygiene. The nurse unzipped and reached into the nursing bag for new gloves, and donned these gloves. The nurse then returned to the wounds and cleansed the abdominal wound nearest the umbilicus with gauze and normal saline, applied xeroform and covered it with bordered gauze, then doffed gloves. The nurse failed to perform hand hygiene. New gloves were donned. The remaining two abdominal wounds were cleansed with the same piece of gauze and saline. The patient had stopped retracting the skin over the remaining sites and the patient's skin fell over the lower site (near the beltline), the loose skin was lifted up out of the way and xeroform was applied, followed by bordered gauze. The middle remaining wound also had a portion of the sweatshirt and skin lay over the site after xeroform had been

applied, and the loose skin was simply lifted up and a bordered gauze was secured in place. (The wounds were not re-cleansed/re-dressed after having been contaminated). Gloves were doffed and placed in the trash. The nurse failed to perform hand hygiene. The nurse unzipped, then entered the nursing bag to retrieve new gloves and donned them. Later, with bare hands, the nurse tied up a trash bag used for wound care, handled and carried this bag to be disposed of in the patient's kitchen trash receptacle.

6. On 2/9/23 at 4:38 PM in an interview with the Administrator, when discussing infection control breaches witnessed during the home observations, she indicated she would have expected the clinicians would have washed their hands in between changing gloves. Also, indicated she would have expected that wound care would have been performed on one site first, and then the other(s). The administrator further indicated she plans to re-educate staff, send out the

	with clinicians on home visits, and review infection control measures with staff. IAC 410 17-12-1(m)			

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
Melissa	Dicke	3/10/2023 4:08:28 PM