STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157452	A. BUILDING B. WING	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS HOME HEALTH SERVICES	621 BROADWAY, NEW HAVEN, IN, 46774

(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 State Department of Health in accordance with 42 CFR 484.102. Survey Dates: September 19, 20, 21, and 22, 2023. Census: 21 At this Emergency Preparedness survey, New Horizons Home Health Services was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR by Area 3 on 09/29/2023.	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State	G0000		

	Relicensure survey of a Home Health Provider. This survey was partially extended on September 20, 2023. Survey Dates: September 19, 20, 21, and 22, 2023 Unduplicated skilled admissions: 12 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QR by Area 3 on 09/29/2023.			
G0446	Contact info Federal/State-funded entities 484.50(c)(10)(i,ii,iii,iv,v) Be advised of the names, addresses, and telephone numbers of the following Federally-funded and state-funded entities that serve the area where the patient resides: (i) Agency on Aging (ii) Center for Independent Living (iii) Protection and Advocacy Agency, (iv) Aging and Disability Resource Center; and (v) Quality Improvement Organization. Based on document review and interview, the agency failed to ensure it provided all patients with the name, address, and telephone number of the QIO (Quality	G0446	1 Corrected 9/23/23. Form with current OIG listed has beenreplaced in all Admission Packets and was mailed to all clients with Octobervisit schedule on 9/28/23. 2 Admission Packets will be reviewed to verify formwith current OIG included for all new admissions for 60 days and 85% of newadmissions for additional 30 days 3 Administrator	2023-10-20

	Improvement Organization that manages all beneficiary complaints and quality of care reviews) for 1 of 1 agency, with the potential to affect all patients of the agency. Findings include: On 09/19/2023, a 2018 document titled "Admission Document" for Area 4 of Indiana was provided by the administrator. The document provided to all patients of the home health agency, represented QIO services provided to Area 4 in Indiana and failed to evidence the correct information for the QIO for Area 4 in Indiana. During an interview on 09/20/2023 at 2:30 PM, the administrator indicated the agency had the incorrect QIO information in the admission documents provided to patients.			
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment.	G0544	1 Patient #3 wound resolved prior to survey. Nurseto document depth of all wounds on Skilled Nursing Visit Note. 2 Agency to review all client charts with currentwounds to	2023-10-20

	The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as 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 record review and interview, the agency failed to ensure the comprehensive assessment was updated and revised to include wound measurements in 1 of 3 active clinical records reviewed with wounds (Patient #3). Findings include: Review of an agency document dated 05/1992 and titled "Wound Assessment and Documentation" indicated a wound assessment is to include the size with measurement of the length, width, and depth. On 09/20/2023, the clinical record for Patient #3 evidenced an agency document titled "Incident Report". The report was completed and signed by home health aide (HHA) 2 on 09/09/2023. The incident report indicated Patient #3 had an open area on the stump of the amputation site below the left knee and that registered nurse (RN) 1 was notified. On 09/09/2023, RN 1 documented		ensure depth measurement is documented on SN wound documentation. Agency to conduct ongoingmonitoring of all SN documentation of wounds in client charts with wounds for60 days. Agency to continue to monitor SN documentation of wounds for at least85% of client charts with wounds for additional 30 days. All skilled employees to receive inservicetraining on Wound Assessment and Documentation. 3 Administrator	

	going to the emergency room on 09/09/2023 to have leg evaluated and would schedule a visit with the patient on the following Monday. Review of an agency document titled "Adult Skilled Nursing Note" completed and signed by RN 1 on 09/14/2023 indicated measurements of the wound on the lateral aspect of left lower stump with length of 1 centimeter (cm) and width of .08 cm. The documentation failed to evidence measurement of the depth of the wound. During an interview on 09/22/2023 at 11:00 AM, RN 1 indicated should have obtained measurements of the length, width, and depth of the wound. 17 IAC 17-14-1(a)(1)(B)			
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	G0574	1 Verbal Order obtained to correct Medicationroute for Patient #1 on 9/19/23. 2 Clinical Managers to review medication routesfor all clients to ensure all medication routes are correct. Agency will monitor all client charts for correct medication route for 60 days and 85% of client charts for	2023-10-20

	equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the home health agency failed to ensure the plan of care included the correct route of administration of medications for 1 of 3 active clinical records reviewed with home visits (Patient #1). Findings include: On 09/22/2023, the administrator provided a revised 01/2018 agency policy		medication routes foradditional 30 days. 3 Administrator	

	Plan/Medical Supervision". The policy indicated the plan of care will include all medications. On 09/20/2023, a clinical record review for Patient #1 evidenced a plan of care (POC) for the period 07/24/2023 through 09/21/2023. The POC evidenced diagnosis, but not limited to, post traumatic seizures (seizure disorder that occurs when the brain experiences damage from physical trauma). The POC indicated the route of administration as oral (by mouth) for medications, Buspirone (to treat anxiety) was to be given two times a day by mouth and Cannabidiol (to manage seizures) two time a day by mouth. The POC indicated the skilled nurse visits were to be scheduled 1-3 times each day and were to administer medications as ordered. The POC evidenced Patient #1 had a gastrostomy tube (surgically placed tube through abdomen into the stomach used to administer feedings, hydration, and medications). The individualized POC failed to evidence the need for Buspirone and Cannabidiol to be administrered by way of a			

	gastrostomy tube. During a home visit on 09/19/2023 at 4:00 PM, observed registered nurse (RN) 1 administer evening medications through the gastrostomy tube. During an interview on 09/19/2023 at 4:20 PM, RN 1 indicated all of patient's medications are administered through the gastrostomy tube. 17 IAC 17-13-1(a)(1)(D)(ix)			
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 used proper hand hygiene (handwashing or use of alcohol-based hand rub) and bag technique to prevent the spread of infection in 1 of 2 home health aide (HHA) home observations, HHA 3, with the	G0682	1 HHA #3 received additional training with RNon proper hand hygiene and bag technique on 10/4/23. 2 HHA #3 will be monitored for continued adherenceto proper hand hygiene and bag technique at client homes during each supervisoryvisit with RN for 60 days. RN will document on supervisory note compliance withInfection Control procedures at visit. All employees with patient contact willcomplete inservice on Handwashing and Bag Technique procedures.	2023-10-20

	potential to affect all patients in which HHA 3 provided direct care. Findings include: On 09/20/2023, the administrator provided an undated agency policy titled "Handwashing". The policy indicated hand washing must be completed before and after the care of patients and after removing gloves. On 09/20/2023, the administrator provided an undated agency policy titled "Bag Technique". The policy indicated items are to be placed on a paper towel and after placement of waste in trash container in patients' home direct care staff are to perform hand hygiene. On 09/20/2023, a home visit with HHA 3 was scheduled with Patient #2. HHA 3 was observed removing their gloves after cleaning the bathroom sink and toilet. HHA 3 removed the waste bag in the bathroom and discarded it into the garbage receptacle in the garage. HHA 3 returned to the bathroom and prepared coffee		3 Administrator	

	located on the bathroom counter. HHA 3 failed to perform hand hygiene and apply/remove gloves appropriately. HHA 3 was observed removing the fabric cover of the table device used for documentation and placed it on the patient's bed with no barrier. HHA 3 failed to protect the equipment by using a barrier before placing the tablet cover on the patient's bed. During an interview on 09/20/2023 at 11:15 AM, HHA 3 indicated hand hygiene should be done after throwing out garbage and before preparing coffee for the patient. During an interview on 09/20/2023 at 3:20 PM, the administrator indicated a paper towel or piece of paper should have been placed between the cover of the tablet and the patients' bed. 410 IAC 17-12-1(m)			
G0768	Competency evaluation 484.80(c)(1)(2)(3)	G0768	1 Agency HHA competency program includes writtencompetency for adequate nutrition and fluid	2023-10-20

	Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. Based on record review and interview, the agency's home health aide (HHA) training program failed to include training regarding adequate nutrition and fluid intake, and maintenance of a clean, safe, and healthy environment with the potential to harm all patients receiving HHA services, for 1 of 1 agency.		intake as well as maintenance of aclean, safe and healthy environment, however those two topics were not on the "skillschecklist" and have been added to document written competency 10/3/23. 2 RN will utilize updated skills checklist for allnew HHA. Current HHAs to receive additional written inservice on AdequateNutrition and Fluid Intake and Maintenance of a Clean, Safe and Healthy Environment. 3 Administrator	

	Findings include: On 09/21/2023, the office administrative assistant, provided an undated agency document titled, "Certified Home Health/Hospice Aide Checklist". The document failed to include the training and the evaluation of skills for adequate nutrition and fluid intake and for maintenance of a clean, safe, and health environment. During an interview on 09/22/2023 at 2:25 PM, the administrator indicated the agency's HHA competency evaluation did not include training and evaluation of adequate nutrition and intake and maintenance of a clean, safe, and healthy environment.			
G1030	Retrieval of records 484.110(e) Standard: Retrieval of clinical records. A patient's clinical record (whether hard copy or electronic form) must be made available to a patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first). Based on record review and	G1030	1 Notice of Privacy Practices updated with thecorrect information on 9/23/23 and mailed to all clients with their Octobervisit schedule. 2 Agency will confirm all Admission Packetscontain the corrected Notice of Privacy Practices document for all new clientsnext 60 days and monitor	2023-10-20

	interview, the agency failed to ensure patient's clinical records would be made available to the patient, free of charge, upon request, at the next home visit or within 4 business days (whichever came first) for 1 of 1 agency. Findings include: On 09/19/2023, a revised 09/2013 admission document titled "Notice of Privacy Practices" was provided by the administrator. The document indicated the patient may be charged a copying fee for medical records and requests for medical records will be acted upon within 30 days after request is made. During an interview on 09/20/2023 at 11:45 AM, the administrator indicated the Notice of Privacy Practices document is not correct. 17 IAC 17-12-3(b)(3)		85% of Admission Packets for additional 30 days. 3 Administrator	
N0000	Initial Comments This visit was for a State	N0000		

	Relicensure survey of a Provider. This survey was partially extended on September 20, 2023. Survey Dates: September 19, 20, 21, and 22, 2023 Unduplicated skilled admissions: 12 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QR completed by Area 3 on 09-29-2023.			
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of	N0464	1 Agency confirmed, per IDOH Deputy Director, thatthe CDC can be used as a Nationally recognized Standard for Employee Tuberculin SurveillanceProgram Policy. Agency adopted CDC Standard 4/2020. Agency completed 100% auditof all HR files for employees with patient contact and confirmed compliancewith	2023-10-20

	tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis		agency adopted CDC Standard for Employee Tuberculin Surveillance Program Policy 2 Agency will continue to follow CDC Standard TuberculinSurveillance Program Policy. Administrator	

examination within the previous twelve (12) months.

Based on record review and interview, the agency failed to ensure all employees who provided patient care, had an annual tuberculin skin test using the Mantoux method (skin test to detect tuberculosis) or a quantiferon assay (blood test to detect tuberculosis) in 1 of 1 registered nurse (RN) employee records reviewed (RN 1), and for 2 of 3 home health aides (HHA) employee records reviewed (HHA 2, 3) for 1 of 1 agency, without documentation of the adoption of a National Standard for the surveillance of Latent TB in healthcare workers.

Findings include:

On 09/21/2023, the administrator provided a revised 04/2020 agency policy titled "Employee Tuberculin Surveillance Program". The policy indicated after baseline tuberculosis testing is done at hire for employees with direct patient contact, no annual testing is done.

On 09/21/2023, a review of the

personnel record of RN 1 indicated a hire date of 10/04/2017, a hire date of HHA 2 on 11/05/2009, and a hire date of HHA 3 on 04/09/2015. The personnel records failed to evidence annual tuberculin surveillance was completed with a tuberculin skin test using the Mantoux method or a quantiferon assay since the baseline testing done on hire. The agency failed to adopt a national standard requiring no annual tuberculosis testing.

During an interview on 09/21/2023 at 3:00 PM, the administrator indicated the provider follows CDC (Center for Disease Control and Prevention) guidelines regarding tuberculosis testing of employees which does not include annual tuberculosis testing of employees providing direct patient care.

During an interview on 09/22/2023 at 2:20 PM, the administrator indicated the provider follows the CDC guidelines and has not adopted a National Standard for surveillance of tuberculosis in employees.

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
Robin Snyder	Administrator	10/13/2023 1:35:21 PM