STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157676	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARRIS-IFY HOME CARE	5445 LAFAYETTE ROAD, INDIANAPOLIS, IN, 46254

(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. Survey Dates: 11-29-2023, 11-30-2023, 12-01-2023, and 12-04-2023 Active Census: 88 At this Emergency Preparedness survey, Larris-Ify Home Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR completed by Area 3 on 12-08-2023.	E0000	NO RESPONSE IS REQUIRED FOR INITIAL COMMENTS	
G0000	INITIAL COMMENTS This visit was for a Federal	G0000	NO RESPONSE IS REQUIRED FOR INITIAL COMMENTS.	

	Recertification and State Re-licensure survey of a Home Health provider conducted by the Indiana Department of Health. Survey Dates: 11-29-2023, 11-30-2023, 12-01-2023, and 12-04-2023 12-Month Unduplicated Skilled Admissions: one (1) This deficiency report reflects State findings cited in accordance with 410 IAC 17. Refer to the State form for additional findings. QR was completed by Area 3 on 12-08-2023. This survey was updated/ modified by SFF on 1/8/2024. CoPs and related deficiencies were removed. Preclusion for aide training and competency was also removed.			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any	G0536	The agency will conduct an in-person in-service for all registerednurses to review the agency policy "Medication Management-Patient Information."A point of	2024-01-04

	potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review, observation, and interview the agency failed to ensure the registered nurse completed thorough reviews of patients' current medication, in 1 of 9 clinical records reviewed. (Registered Nurse 1, Administrative Personnel 5) (Patient #7) 1. A policy titled "MEDICATION MANAGEMENT-PATIENT INFORMATION" received from the agency indicated but was not limited to "PURPOSE: To facilitate continuity of care, treatment and/or services ... by providing accurate and comprehensive information about patients' medications ... The Registered Nurse shall generate a list of the patient's current medications and herbal remedies ... documented in the initial assessment ... the list of medications is incorporated into the plan of care ... A copy of the completed medication list remains in the patient's home chart ... medications are reviewed and assessed during		emphasis will be following Larris' policy to capture everymedication (prescription and over the counter) vitamins, herbal supplement,ointments, creams, etc. the patient is using. The review must include observation/ physical inspection of thepatient's medications to document the date filled, name of the medication, typeof medication (capsule, pill, inhaler, etc.,) strength, route, dosage toinclude time/times and if an as needed medication, the reason for the PRNmedication to be used. Also, clinicianswill be instructed to ask the patient or patient representative if there areany new, changed, or discontinued medications every time they are in thepatients' home. Medicationreconciliation and identification of potential adverse effects, druginteractions, ineffective drug therapy, significant side effects, significantdrug interactions, duplicate drug therapy and non-adherence will be identified anddocumented in the clinical record. Notification will be sent/faxed to theattending physician and any other pertinent provider, and the	

	each skilled visit. Any changes … are conveyed to the ordering physician …. " 2. The clinical record for Patient #7 contained a Plan of Care with a Start of Care date of 04-20-2023 and a certification period of 10-17-2023 to 12-15-2023 with diagnoses which included, but were not limited to: Type 2 Diabetes Mellitus (a condition that occurs due to a problem in the way the body regulates and uses sugar as a fuel) with diabetic neuropathy (a type of nerve damage that can occur with diabetes, most often affecting the legs and feet), hypertensive chronic kidney disease stage 2 (a condition where elevated blood pressures cause mild damage to the kidneys) Human immunodeficiency Virus (virus that attacks the body's immune system, if not treated, can lead to AIDS (acquired immunodeficiency syndrome) there is currently no effective cure), long term use of insulin, long term use of aspirin. Skilled Nursing frequency was 1 time per week for 9 weeks for medication education and disease management. Medications listed on the Plan		response and/or orders will bedocumented and implemented as appropriate. Any registered nurse who does not attend the in-service at the officewill not be allowed to work until the content has been made up. The Quality Assessment and Performance Improvement committeewill monitor compliance with the requirement for medication review andmedication reconciliation to be accurate and complete to capture allmedications the patient is using. Allthe patients' medication profiles will be reviewed each 30 days for 6 monthsuntil 100% compliance has been established and the agency has assurance thatmedication profiles are complete and accurately reflect all of the patients'medications and that medication reconciliation is being completed to includephysician notification/response where indicated. If 100% compliance is not achieved each 30 days of the 6 monthsmonitoring period, the monitoring will be extended	

	of Care: "JARDIANCE (an antidiabetic medication used to improve glucose control in people with type 2 diabetes) 10 MG ORAL TABLET ... TAKE ONE TABLET BY MOUTH DAILY ... LORSARTAN (used to treat high blood pressure (hypertension) and to help protect the kidneys from damage due to diabetes) 100 MG ... TAKE ONE TABLET BY MOUTH DAILY ... TRIUMEQ (for the treatment of HIV/AIDS, a combination of three different medications) [no dosage recorded] ORAL TABLET ... TAKE ONE TABLET BY MOUTH DAILY ... LEVOTHYROXINE (used to treat an underactive thyroid gland (hypothyroidism) replaces the missing thyroid hormone thyroxine) 50 MCG TAKE 1 TABLET BY MOUTH [sic] DAIY ... ABACAVIR/DOLUTEGRAVIR/LAMIVUDINE (generic name for Triumeq) 600 MG-50MG-300 MG ORAL TABLET ... TAKE 1 TABLET BY MOUTH DAILY ... PRAVASTATIN (from a class of drugs called 'statins', may treat high cholesterol and triglyceride levels) 20 MG ORAL TABLET ... TAKE ONE TABLET BY MOUTH DAILY ... AMLODIPINE (used to treat high blood pressure		another 30 days until theagency has attained 100 % compliance and the agency has assurance that medication review isbeing conducted correctly, that medication reconciliation is being done, thatphysician notification of significant interactions has been made and a responsehas been received by the agency. The completion date is 01/04/2024. The responsible person is the Administrator.	

	and chest pain) 5 MG ORAL TABLET ... TAKE ONE TABLET BY MOUTH DAILY ... ASPIRIN (can treat pain, fever, headache, and inflammation. It can also reduce the risk of heart attack) 81 MG ... TAKE ONE TABLET BY MOUTH DAILY ... TRIAMTERENE-HYDROCHLOROTHIAZIDE (used to treat high blood pressure, works by helping your kidneys remove fluid and salt from your blood through urination) 75 MG-50 MG ORAL TABLET ... TAKE ONE TABLET BY MOUTH DAILY ... ALPHA LIPOIC ACID (an antioxidant that is made naturally in the body and also found in foods, used to break down carbohydrates and to make energy) [no dosage recorded] ... TAKE ONE TABLET BY MOUTH DAILY ... INSULIN GLARGINE (injection that treats diabetes by increasing insulin levels in the body, decreasing blood sugar levels) SOLOSTAR PEN 20 UNITS INJECT 47 UNITS UNDER THE SKIN EVERY MORNING SUBCUTANEOUS ... DOXAZOSIN (can treat urinary problems caused by an enlarged prostate, can also treat high blood pressure when used alone or in combination with			

	other medications) 1 MG ORAL TABLETS ... TAKE TWO [sic] TABLET BY MOUTH EVERY BEDTIME ..." The Plan of Care was signed 10-16-2023 by Administrative Personnel 5. The Plan of Care failed to evidence all medications the patient was actively taking, change in dosage of active medications, failed to identify duplications, and failed to ensure medications no longer in use were marked as discontinued. The clinical record for Patient #7 also contained a 'MEDICATION PROFILE' which listed the patient's 'active' medications: "NORCO (combination medication is used to relieve moderate to severe pain, contains an opioid pain reliever (hydrocodone) and a non-opioid pain reliever (acetaminophen)) 5MG-325MG ORAL TABLET TAKE 1 TABLET BY MOUTH EVERY 8-12 HOURS DAILY ... PRAVASTATIN 20 MG ORAL TABLET, EXTENDED RELEASE TAKE 1 TABLET BY MOUTH DAILY ... LEVOTHYROXINE 60 MCG TAKE 1 BY MOUTH DAILY ...			

	TABLET TAKE 1 TABLET BY MOUTH DAILY ... LOSARTAN 100 MG ORAL TABLET BY MOUTH DAILY ... ASPIRIN 81 MG TAKE 1 TABLET BY MOUTH DAILY ... LEVOTHYROXINE [no dosage written for this second entry] TAKE 1 BY MOUTH DAILY ... AMLODIPINE 5 MG TABLET BY MOUTH COMBINE WITH A 2.5 MG FOR A TOTAL OF 7.5 MG ... LANTUS SOLOSTART PEN 100 UNITS/ML SUBCUTANEOUS SOLUTIONS INJECT 20 UNITS DAILY ... AMLODIPINE 2.5 MG ORAL TABLET TAKE 1 TABLET BY MOUTH DAILY COMBINE WITH A 5MG TO EQ [sic] LY LY COMBINE WITH A 5MG ..." The list also contained the following 'active' duplicated medications: "NIFEDIPINE (EQV-ADALAT CC) (antihypertensive drug and calcium channel blocker used to treat high blood pressure and chest pain) 60MG ORAL TABLET, EXTENDED RELEASE TAKE 1 TABLET BY MOUTH DAILY" (appeared twice), "TRIUMEQ ORAL TABLET 600-60-300 TAKE 1 TABLET BY MOUTH DAILY" and "ABACAVIR/DOLUTEGRAVIR/LAMIVUDINE 600 MG-50 MG- 300 MG ORAL TABLET TAKE 1			

	TABLET BY MOUTH DAILY" (these are the same medication). The Medication Profile failed to evidence all medications the patient was actively taking, change in dosage of active medications, failed to identify duplications, and failed to ensure medications no longer in use were marked as discontinued. During a home observation of HHA 1 with Patient #7, the agency folder in the home was reviewed and the patient was queried regarding its contents. Patient #7 indicated they had no medication list provided to them by the agency, nor a Plan of Care. When queried regarding current medications, the patient indicated a bottle of Gabapentin (used to relieve chronic neuropathic, or nerve pain) on the table was picked up from the pharmacy the previous day, prescribed as, "800 mg, 2 P.O. (by mouth) three times per day with meals". The patient indicated had been taking this for more than 1 year to combat the pain in their legs. Patient #7 indicated had been a diabetic for 37 years and			

	injected their own insulin every morning. Indicated was taking Lantus, and that this had recently been increased to 55 units every morning. Patient #7 brought more medication to the table and indicated these were all the medications currently being taken: Pravastatin 20 mg one by mouth daily, Tradjenta 5mg by mouth daily, Amlodipine 5mg by mouth daily, Losartan 100mg by mouth daily, Jardiance 25mg by mouth daily, Triumeq (abacavir 600mg/dolutegravir 50mg/lamivudine 300mg) one by mouth daily, Amlodipine Besylate 2.5mg by mouth daily, Levothyroxine 50mcg by mouth daily. The patient indicated they did not have Aspirin or Doxazosin. Indicated was no longer taking Nifedipine. During the Entrance Conference, when queried as to the process of drug regimen review, the Director of Nursing indicated medications were reviewed with every skilled nursing visit, the medication list is reviewed with patient, communication is made with the provider to ensure medications are accurate, and that clinicians should have the			

	physical medications present for review, "go get the bottles". In a telephone interview with Person 10, a Pharmacist with Entity 9, indicated the patient's current regimen included the following, "Lantus Solostar 55 units every morning ... Triumeq one daily ... Amlodipine 7.5mg (2.5mg and 5mg) daily ... Jardiance 25mg one daily ... Gabapentin 800mg three times daily ... Levothyroxine 50 mcg one daily ... Tradjenta 5 mg one daily ... Losartan 100mg one daily, Pravastatin 20mg ... [patient] has not picked this up, needs new prescription ... no refills left ... Triamterene/HCTZ 75/50mg ... [patient] needs a new prescription, no refills left ... test strips were last filled 12-29-2022 ... lancets were last picked up 11 months ago, 01-12-2023 ... [patient] has not picked up Alpha Lipoic Acid since 05-10-2023 ..." In a telephone interview with Registered Nurse (RN) 1, when queried as to what is done in a home visit for Patient #7 who is on services for medication education, RN 1 indicated that Patient #7 is seen once a week			

	and that the patient was visited the previous day. Indicated that during nursing visits the patient's vital signs are recorded, lungs are listened to, and blood sugars are checked. When queried as to when medications are reviewed with the patient, RN 1 indicated the patient is asked every visit if there are any new medications. When queried as to when medications are reconciled, RN 1 indicated medications are reconciled at recertification. Indicated when visits are made, the patient has their medications on the kitchen table and these are reviewed. RN 1 indicated would also note when refills are needed and tell the patient to get new refills, when queried as to whether that needed to be done at yesterday's visit RN 1 indicated they did not need to do that yesterday. When queried if RN 1 was aware the patient had a recent increase in their Lantus dosage, the nurse indicated was unaware. RN 1 indicated whenever there is a new medication or changes to medication, he/she calls Administrative Personnel 5 in the office who then calls the provider, or sometimes will call			

	the provider themselves. When queried as to what the patient's medication list is compared to during medication reconciliation, indicated he/she believes the agency provides a list from the provider's office. RN 1 indicated was also unaware of the duplicate medications and discrepancies between the Plan of Care, the Medication Profile, and what was found in the home, and had nothing further to offer. When queried as to whether the Medication Profile on the agency's Electronic Medical Records System was current and accurate, Administrative Personnel 5 indicated it was current and indicated this would be the same as what would be given to patients. When shown the medication list on Patient #7's Plan of Care versus the Medication Profile, and noted each document contained conflicting information, Administrative Personnel 5 indicated was surprised by this finding and the discrepancies should not exist. When queried regarding the multiple discrepancies between Patient #7's Plan of Care,			

	Medication Profile, what was found in the Patient's home, and what was confirmed with Person 10, a pharmacist with Entity 9, Administrative Personnel 5 and Administrator indicated there should be no duplicated medications. When informed Patient #7 had no visit schedule, no medication list, and no Plan of Care in the home, the Administrator and Alternate Administrator indicated these items should be in the patient's home and updated after every recertification, and indicated they expected the RN would hand deliver these items to the patients home. 410 IAC 17-14-1(a)(1)(B)			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review, and interview the agency failed to ensure patients were provided with a written schedule detailing staff visit	G0614	The agency will distribute to every active patient a copy oftheir visit schedule and remind patients Larris can replace the visit schedule anytime it is misplaced. The agency will conduct an in-person in-service for allagency staff to review the necessity of providing and updating every patientsvisit	2024-01-04

	frequency, in 2 of 3 home visits observed. (Patients #2 and #7). Findings include: 1. During a home visit at Patient #2, a review of their agency folder failed to evidence a written schedule of staff. When queried how do they know when staff is going to be there, Patient #2 indicated the staff usually calls the day before to let them know, but we have a system worked out now and it's all good. 2. On 12-01-2023 at 4:26 PM, the Administrator indicated the nurse should be putting a schedule in every patient's folder. 3. During a home observation of HHA 1 with Patient #7, the agency folder in the home was reviewed and the patient was queried regarding its contents. The patient indicated there was not a 'visit schedule' from the agency and if there was, did not know where it might be. 4. On 12-01-2023 at 4:20 PM when informed Patient #7 had no visit schedule, no medication list, and no Plan of Care in the		schedule with a written copy presented in their homes. Any time a patient has misplaced their visitschedule, a new one will be provided. Therewill be examples of failures to do so discovered during the survey used as a basis for discussion/learning. Time will be reserved for a question andanswer session. Any employee who doesnot attend the in-service will not be allowed to work until the content hasbeen made up.	

	Alternate Administrator indicated these items should be in the patient's home and updated after every recertification, and indicated they expected that the RN would hand deliver these items to the patients home.		The Quality Assessment and Performance Improvement committeewill monitor compliance with the requirement that patients have been provided avisit schedule. 100% active patients will be contacted to ensure they have acopy of their visit schedule in their home. Clinicians with deliver these schedules at visits/assessments and somewill be mailed if appropriate. The Director of Nursing will verify visit scheduleshave been provided to each patient every 30 days for 6 months until 100% compliance hasbeen established and the agency has assurance that patients have a written copyof their visit schedule. If 100% compliance is not achieved each 30 days of the 6months monitoring period, the monitoring will be extended another 30 days until100% compliance is achieved. The completion date is 01/04/2024. The responsible person is the Administrator.	

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, observation, and interview the agency failed to ensure patients had written medication schedules/instructions for current medication regimen in the home, for 2 of 3 home visits observed. (Registered Nurse (RN) 1 and PT 1) (Patients #2, and #7) Findings include: 1. A policy titled "MEDICATION MANAGEMENT-PATIENT INFORMATION" indicated but was not limited to "PURPOSE: To facilitate continuity of care, treatment and/or services … by providing accurate and comprehensive information about patients' medications … The Registered Nurse shall generate a list of the patient's current medications and herbal	G0616	The agency will distribute to every active patient a copy oftheir medication schedule and instructions and remindpatients Larris can replace their list of medications upon request or any time it is misplaced. The agency will conduct an in-person in-service for allagency staff to review the necessity of providing and updating every patients' medication schedule and instructions with a written copy presented in their homes. Any time a patient has misplaced their medication regimen, a new one will be provided. Therewill be examples of failures to do so discovered during the survey used as a basis for discussion/learning. Time will be reserved for a question andanswer session. Any employee who doesnot attend the in-service will not be allowed to work until the content hasbeen made up. The Quality Assessment and Performance Improvement committeewill monitor	2024-01-04

	remedies ... documented in the initial assessment ... the list of medications is incorporated into the plan of care ... A copy of the completed medication list remains in the patient's home chart ... medications are reviewed and assessed during each skilled visit. " 2. During a home visit at Patient #2, a review of their agency folder failed to evidence a written medication schedule with instructions on their current medication regimen. Patient #2 indicated they've been taking the same medication for a long time. When queried if staff ever teaches about the medications they're taking, Patient #2 smiled and said they've been taking the same medication for a long time. 3. During a home observation of HHA 1 with Patient #7, the agency folder in the home was reviewed and the patient was queried regarding its contents. Patient #7 indicated they had no medication list/schedule provided to them by the agency, nor a Plan of Care.		requirement that patients have been provided theirmedication regimen and instructions. 100% of active patientswill be contacted to ensure they have a copy of their medication regimen with instructions intheir home. Clinicians with deliverthese at visits/assessments and some will be mailed ifappropriate. Clinicians will document in the Communication Notes or the visit notes that a current list of medications has been delivered to the patient. The Clinical Manager (Director of Nursing) will verify visit scheduleshave been provided to each patient by reviewing the clinical record communication note documenting a copy of their medication regimen and instructions has been received every 30 days for 6 months until 100% compliance hasbeen established and Larris has assurance that patients have a written copyof their visit schedule.	

	4. During an interview, the Administrator indicated with recertification the nurse is to deliver the medication list to the patients.		If 100% compliance is not achieved each 30 days of the 6months monitoring period, the monitoring will be extended another 30 days until100% compliance is achieved. The completion date is 01/04/2024. The responsible person is the Administrator.	
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager. Based on record review and interview the agency failed to ensure the patients have the correct information to contact the HHA's clinical manager via phone or email in 2 of 3 home visits conducted. (Patients #2 and 6) Findings include: 1. A policy titled PATIENT CONCERNS/GRIEVANCES received from the agency indicated but was not limited to "To support and respect	G0622	The agency staff will distribute to every active patient the name and contact information for the Clinical Manager (Director of Nursing.) Also, the start of care packet information will be updated for all new patients the agency accepts onto service. Distribution of the name and contact information for the clinical manager will be through a combination of mailing and/or clinicians providing this information at their next visit. The agency will conduct an in-person in-service for allagency staff to review the necessity of patients having the name and contact information for the Clinical Manager. Any time a patient has misplaced this information, upon request	2024-01-04

	concerns/grievances about their care . . . heard . . . The information provided shall include the phone number, contact person . . . . " 2. A review of a Governing Body minutes dated 05-04-2023 evidenced the Agency had appointed Employee 3, a Registered Nurse as the Director of Nursing/Clinical Supervisor in April of 2023 and the Administrator appointment was approved by The Indiana Department of Health on 04-01-2023. 3. During a home observation of Patient # 6, the Patient's Agency folder contained a document listing the Agency's phone number, and the space for Administrator and or Clinical Supervisor was blank. 4. When queried the alternate Administrator reported staff were to white out the name and put the new information about the Administrator and Clinical Supervisor in the patient's information. 5. During a home observation with Patient #2, the Patient's Agency folder contained a		the agency will provide it again. Therewill be examples of failures to do so discovered during the survey used as a basis for discussion/learning. Time will be reserved for a question andanswer session. Any employee who doesnot attend the in-service will not be allowed to work until the content hasbeen made up. The Quality Assessment and Performance Improvement committeewill monitor compliance with the requirement that patients have been provided the name and contact information for the Clinical Manager. Clinicians with deliverthese medication profiles at visits/assessments and some will be mailed ifappropriate. The Clinical Manager will verify 100 % of active patients have her name and contact information by calling them and inviting them to contact her as needed. Any new patient admitted onto service will have the updated start of care packet provided which will contain the correct/updated name and contact of the Clinical Manager. If 100% compliance is not	

	phone number and listed Person 12 as the contact person. During an interview, Patient #2 indicated they had all of their numbers, but could not identify who the contact person would be at the agency. They indicated they would call PT 1 if anything was needed.		achieved each 30 days of the 6months monitoring period, the monitoring will be extended another 30 days until100% compliance is achieved. The completion date is 01/04/2024. The responsible person is the Administrator.	
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 record review, observation, and interview, the agency failed to ensure field staff followed appropriate infection control practices per agency policy while providing patient care in 1 of 3 home visits conducted. (Patient #7) Findings include: A policy titled "NURSING BAG	G0682	The agency staff (office and field staff, direct andcontracted) will all receive in-service education in person regarding theimplementation of our Infection Control policies. The in-service willinclude each employee being provided a copy of the policy, reinforcement ofrecognition and prevention of breaches in infection control prevention. Examples of situations invoking infection control prevention will be discussed with clinician participation. There will be a question and answer period provided. Any employee who misses the mandatory officemeeting for this in-service will not be allowed to work until they complete the infection	2024-01-04

	the agency indicated but was not limited to "When the visit is completed . . . Reusable equipment shall be cleaned using alcohol, antiseptic spray/towlette [sic] and/or soap and water as appropriate:" During a home visit at Patient 2's home to observe PT 1, PT 1 entered and washed their hands using the patient's bar soap at the patient's bathroom sink, created a barrier appropriately, removed all supplies from the bag including a cloth gait belt, placed on one side of the barrier, began an assessment of Patient #2, placing all used equipment on the other side of the barrier. PT 1 placed the cloth gait belt around Patient #2, to assist with standing until Patient #2 indicated they needed to sit. PT 1 removed the gait belt and placed it with other dirty equipment. PT 1 used hand hygiene appropriately when doffing and donning gloves. After ensuring Patient #2 was in their chair comfortably, at 9:37, PT started to place items back into their bag including the gait belt. During an interview, PT 1		control content. The Quality Assessment and Performance Improvement committeewill monitor compliance with the requirement to maintain infection prevention/infection control practices for all patient care. The Clinical Manager (Director of Nursing) will conduct pop visits for observation of 100 % of clinicians' infection control technique. She will do these observations and record the results. Infection prevention and ability to follow the agency's policy will continue to be monitored for 6 months and 100% compliancehas been established and the agency has assurance that clinicians are using proper infection control techniques. If 100% compliance is not achieved each 30 days of the 6months monitoring period, the monitoring will be extended another 30 days until100% compliance has been achieved and the agency has assurance that clinicians are following Larris' policy. The completion date is	

	sanitizer on the equipment before placing the items back into his bag, and when queried about the cloth gait belt, PT 1 indicated they could not clean the belt before placing it in their bag, and that they were taught to clean everything before placing items in their bag. The Administrator indicated PT 1 knows to clean their equipment before placing the items in their bag. 410 IAC 17-12-1(m)		01/04/2024. The responsible person is the Administrator.	
G1026	Retention of records 484.110(c)(1)(2) Standard: Retention of records. (1) Clinical records must be retained for 5 years after the discharge of the patient, unless state law stipulates a longer period of time. (2) The HHA's policies must provide for retention of clinical records even if it discontinues operation. When an HHA discontinues operation, it must inform the state agency where clinical records will be maintained. Based on record review and interview the agency failed to evidence the retention of clinical records for patients for	G1026	The agency will continue to work with AXXESS (electronic clinical record company) to safely restore the clinical entries identified to this closed patient record. Larris will review all of their clinical records to ensure they are complete with all pertinent documents and will restore any records that are determined to not be accessible using instructions provided by AXXESS or alternatively AXXESS will correct their program so all entries can be accessed without the risk of corrupting files. This deficiency will be corrected 100% and compliance will be maintained by chart reviews for 6 months. The date of correction is 01/04/2024. The responsible person is the Administrator.	2024-01-04

	9/11/21 through 11/8/21 in 1 of 2 discharged records (Patient #1), of 9 patient records reviewed. Findings include: 1. A policy titled " Maintenance and Retention of Clinical Records" received from the administrator contained but was not limited to "To Maintain the integrity and security of clinical records while allowing access to the records ... Clinical Records of adult patients are retained for a minimum of seven (7) years ... or according to state law ... All material shall be available for review by ... Department of Health ... during the retention period." 2. During the entrance conference on 11-29-23 at 9:56 AM the agency reported they had changed their electronic record system in 2023 and maintained closed files in a locked room in a locked filing cabinet. On 12-04-2023 at 9 AM a request to the Alternate Administrator was made for Patient # 1's skilled nursing visit notes for December 2021,			

	communication notes for December 2021, physician orders, resumption of care Oasis for January 2022, and communication notes, skilled nursing visits and physician orders for 2023. On 12-04-2023 at 1:24 PM the Alternate Administrator reported they were unable to provide all of the requested information in 2021 and 2022 as their electronic medical records provider reported there was no way to restore the information without corrupting the files. They reported it would take 30-60 days from this point forward to restore and access the past files and they might be able to retrieve some patients but the current issue was the migration of information from the old system to the new system. On 12-01-2023 at 1:45 this surveyor was not able to view the skilled nursing visits for Patient #1 from 11-10-2021 through and including 11-26-2021 utilizing the agency's EMR system. Upon requesting skilled nursing visits for Patient #1, 11-10-2021			

	11-26-2021, the Alternative Administrator indicated they could not restore those visits without corrupting the files, and they would be destroyed.			
N0000	Initial Comments This visit was for a State Re-licensure survey of a Home Health provider, conducted by the Indiana Department of Health. Survey Dates: 11-29-2023, 11-30-2023, 12-01-2023, and 12-04-2023. 12-month Unduplicated Skilled Admissions: one (1) Larris-IFY Home Care was found to be out of compliance with 410 IAC 17 in regard to a State Re-licensure survey. QR completed by Area 3 on 12-10-2023.	N0000	No response is required for Initial Comments.	
N0458	Home health agency administration/management	N0458	Larris office staff responsible for personnel records will all	2024-01-04

	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. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review the agency failed to follow the Indiana Code requirements to ensure all employees caring for patients had an unlimited /extended criminal background check upon hire and within 3 days of patient contact in 1 of 8 records reviewed (Employee 1, Physical Therapist) and failed to complete an annual evaluation in 4 of 5 employees eligible for review. (Home Health Aide (HHA) 1, HHA 3, Physical Therapist (PT) 1, and the Clinical Nurse Supervisor.)		receive an in person in-service education regarding the correct implementation of Larris' "Performance Evaluations," and" National Background Checks." Any office employee who misses the mandatory officemeeting for this in-service will not be allowed to work until they complete thecriminal background check and performance evaluation content. Emphasis will be on the need to conduct performance evaluations on all employees each 9-15 months and to obtain a national or expanded criminal background check on all employees who provide care in the patients' home. The Quality Assessment and Performance Improvement committeewill monitor compliance with the requirement to complete annual performance evaluations and timely obtain expanded or national criminal background checks by completing personnel file audits on all direct care employees to catch up on overdue performance evaluations and to run expanded or national criminal background checks if the	

	Findings include: 1. Employee Criminal History Checks- IC-16-27-2-4 "Employees; criminal history. Section. 4 (a) A person who operates a home health agency under IC16-27-1 or personal services agency under IC 16-27-4 shall apply, not more than three (3) business days after the date that an employee begins to provide service in a patient's temporary or permanent residence, for a copy of the employee's criminal history checks... Section 4 (b) A home health agency or personal services agency may not employ a person to provide services in a patient's or client's temporary or permanent residence for more than three (3) business days without applying for a national criminal history background check or an expanded criminal check . . . ." 2. A policy titled, "PERFORMANCE EVALUATIONS" indicated but was not limited to, " Ongoing performance evaluations are to be conducted at the minimum of once every nine (9) to fifteen (15) months, or more frequently		employee has no background check or a limited background check in their personnel file. If 100% compliance is not achieved each 30 days of the 6months monitoring period, the monitoring will be extended another 30 days until100% compliance is achieved and Larris has assurance the Indiana Code and Larris policy has been implemented. The completion date is 01/04/2024. The responsible person is the Administrator.	

according to the organization's policies, state laws or regulations. "

3. A policy titled "NATIONAL BACKGROUND CHECKS" indicated but was not limited to "Larris-IFY Home Care HHA performs background screening on all final candidates for employment . . . National background history . . . shall be checked prior to being hired . . . . "

4. A review of the personnel file for PT 1 evidenced a date of hire of 10-20-2014 and an annual evaluation dated 2020 and failed to evidence of a national criminal history background check or expanded criminal check.

5. A review of the personnel file for HHA 1 evidenced a hire date of 09-27-2019 and failed to evidence any annual evaluations were completed

6. A review of the personnel file for HHA 3 evidenced a hire date of 09-20-2021 and failed to evidence any annual evaluations were completed.

7. A review of the Personnel file

	evidenced a hire date of 08-30-2022 and failed to evidence any annual evaluations were completed. 8. The Alternate administrator reported they could not locate annual evaluations for requested 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
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