STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157536	A. BUILDING B. WING	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOME CARE SERVICES	303 E 89TH AVENUE, SUITE A, ROOM 117, MERRILLVILLE, IN, 46410

(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 Condition of Participation for Home Health Agencies. Survey Dates: 12/12/2024 to 12/13/2024 and 12/16/2024 to 12/18/2024 Active Census: 95 At this Emergency Preparedness survey, Methodist Home Care Services was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State	G0000		

	Re-Licensure survey of a Home Health Provider. Survey Dates: 12/12/2024 to 12/13/2024 and 12/16/2024 to 12/18/2024 12-Month Unduplicated Skilled Admissions: 880 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. On 12/16/2024 at 12:16 PM, Administrator was notified the survey was partially extended. Abbreviations used in report: Registered Nurse [RN], Clinical Manager [CM], Clinical Supervisor [CS], Skilled Nurse [SN, Plan of Care [POC], Home Health aide [HHA], start of care [SOC]**,** Physical Therapist [PT], Social Worker [SW], and Occupational Therapist [OT]. QR: 12/29/2024 A1			
G0460	Patient refuses services 484.50(d)(4) The patient refuses services, or elects to be	G0460	**<u>ACTIONS TAKEN:</u>** The Administrator worked with Quality Coordinator andrevised *<u>Discharge and Transfer Policy</u>*for	2025-01-17

	transferred or discharged; Based on record review and interviews the agency failed to evidence they educated patients, who declined services and requested to be discharged from home health services, on the risks and potential adverse outcomes that may result from discontinuation of services in 2 of 5 closed clinical records reviewed (Patients # 9, 12). Findings include: 1 .The clinical record for Patient #9 included a POC dated 11/1/2024 to 12/30/2024 with services ordered for PT visits once a week for one week then twice a week for four weeks and an OT evaluation dated 11/8/2024 that indicated OT visits were planned once a week for four weeks. The record included documentation of missed visits due to Patient cancellation with PT on 11/11/2024, 11/19/2024, and 11/21/2024, and missed OT visits were documented for 11/15/2024 and 11/22/2024. Documentation of discharge, dated 11/26/204, indicated Patient was discharged due to noncompliance. The clinical record failed to evidence education was provided to Patient regarding the risks and		clarity with specific guidelines regarding patient noncompliance anddischarge. The Administrator educated all staff regarding requirementto educate patient/patient legal representative regarding risks and potentialadverse outcomes resulting from discontinuation of home care services. Educationincluded a verbal presentation and printed handout of material. **Responsible Person**:Home Health Administrator **Completed:** 1/17/2025 **<u>PREVENTRECURRANCE:</u>** RN Case Managers will review all pending discharges toensure patients have received education regarding possible risks or adverseoutcomes as a result of discharge from home care services. Noncompliance willbe reported to Home Health Administrator who will contact patient/patientrepresentative. **Responsible Person:**Home Health Administrator	

	potential adverse outcomes related to missed visits or an early discharge from home health services. During an interview on 12/18/2024 beginning at 2:00 PM, CM relayed there was not documentation that Patient was educated regarding the risks or potential adverse outcomes due to not completed the ordered home health services. 2. The clinical record for Patient #12 revealed an initial SOC comprehensive assessment dated 9/14/2024 that indicated Patient was alert and oriented to person, place and time with forgetfulness. The POC dated 9/14/2024 to 11/13/2024 included services SN once a week for one week then twice a week for four weeks. The 9/17/2024 SN visits was a missed visits due to the Patient not answering the phone. The record included documentation that on 9/19/2024, SN called Patient, spoke to Patient's family member, Other F, who indicated Patient would like to discontinue home health services. The clinical record included a discharge order dated 9/19/2024; the record		**Goal:** 100% **Completed:** Auditing initiated 1/16/25. Auditing willcontinue until 100% compliance is maintained for 3 consecutive months at whichpoint auditing may be reduced to random review (10% of total patient census perquarter or minimum of 30 charts).	

	failed to evidence education was provided of risks nor potential adverse effects from early discharge from services. During an interview on 12/18/2024 beginning at 10:00 AM, Administrator relayed there was not documentation of education regarding adverse effects from an early discharge to Patient nor Other F.			
G0464	Advise the patient of discharge for cause 484.50(d)(5)(i) (i) Advise the patient, representative (if any), the physician(s) or allowed practitioner(s), issuing orders for the home health plan of care, and the patient's 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) that a discharge for cause is being considered; Based on record review and interviews the agency failed to evidence the patient, or their designated decision maker, was advised that discharge was imminent in 1 of 1 closed clinical record reviewed with a diagnosis of alcohol use (Patient #12). Findings include: The clinical record for Patient #12 revealed an initial start of	G0464	**ACTIONS TAKEN:** The Administrator educated all staff on the need to discuss caredecisions/obtain consent from only patient or patient legal representative whendiscussing discharge decisions. Education included a verbal presentation and printedhandout of material. **Responsible Person**:Home Health Administrator **Completed:** 1/17/2025 **PREVENTRECURRANCE:** Quality coordinator will audit	2025-01-17

	care comprehensive assessment dated 9/14/2024 that indicated Patient was alert and oriented to person, place and time with forgetfulness and a primary diagnosis of alcohol use and withdrawals. The POC dated 9/14/2024 to 11/13/2024 included services SN once a week for one week then twice a week for four weeks. The 9/17/2024 SN visit was a missed visits due to the Patient not answering the phone, resulting in zero skilled nurse visits during week 2 of certification period. A communication documentation on 9/19/2024 indicated the SN called Patient and spoke to Patient's family member, Other F, who indicated Patient would like to discontinue home health services. The clinical record included a discharge order dated 9/19/2024. The clinical record failed to evidence notification nor discussion directly with Patient regarding discharge. The clinical record failed to evidence power of attorney nor health care representative documentation regarding Other F as a designated decision maker for Patient.		fordocumentation reflecting patient/patient caregiver were informed and educatedregarding discharge and potential adverse outcomes. Quality coordinator will report audit findingsto Home Health Administrator. **Responsible Person:** HomeHealth Administrator **Goal:** 100% **Completed:** Auditingwas initiated 1/16/25. Auditing will continue until 100% compliance ismaintained for 3 consecutive months. At that point, auditing may be reduced torandom review (10% of total patient census per quarter or minimum of 30 charts).	

	During an interview on 12/17/2024 beginning at 2:15 PM, CM relayed Other F notified staff that Patient did not want home health services, and the family member was listed as Patient's emergency contact and relayed the record failed to evidence staff spoke with Patient regarding discharge. 410 IAC 17-12-2(i)			
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interviews the agency failed to ensure the skilled professional conducted an initial assessment within 48 hours of referral or patient's return home in 1 of 3 active clinical records with PT only services (Patient #3) and 2 of 5 closed clinical records reviewed (Patients #8, 9). Findings include:	G0514	**ACTIONS TAKEN:** The Administrator educated all staff regarding need tocomplete initial patient assessment within 48 hours of referral or 48 hours ofpatient return home or on the physicians ordered start of care date. Educationincluded a verbal presentation and printed handout of material. **Responsible Person:** Home Health Administrator **Completed**: 1/17/2025 **PREVENTRECURRANCE:** Quality coordinator to audit	2025-01-17

	1.The clinical record for Patient #3 revealed a referral for home health PT services dated 11/26/2024. An initial comprehensive assessment was completed on 11/29/2024 by PT 1. The clinical record failed to evidence documentation of physician notification nor order for the delay in the start of home health care. During an interview on 12/16/2024 starting at 3:00 PM, CM relayed there was not documentation regarding the delay in care. She indicated the delay was due to a holiday on 11/28/2024. 2. The clinical record for Patient #8 revealed a referral for home health including a SN and HHA dated 8/21/2024 signed by Patient's physician. An initial visit that included a comprehensive assessment was completed on 8/25/2025. The clinical record failed to evidence documentation of physician notification nor order for the delay in the start of home health care. During an interview on 12/17/2024 beginning at 2:15		forcompliance. Quality coordinator will report audit findings to Home HealthAdministrator. **Responsible Person:** HomeHealth Administrator **Goal:** 100% **Completed:** Auditingof records was initiated on 1/16/2025**.** Auditingwill continue until 100% compliance is maintained for 3 consecutive months. Atthat point, auditing may be reduced to random review (10% of total patientcensus per quarter or minimum of 30 charts).	

	was not documentation regarding the delay in the agency start of home health care. 3. The clinical record for Patient #9 revealed a referral for home health including PT and OT dated 10/29/2024 and signed by Patient's physician. An initial visit that included a comprehensive assessment was documented 11/1/2024. The clinical record failed to evidence documentation of physician notification nor order for the delay in the start of home health care. During an interview on 12/17/2024 beginning at 2:15 PM, Administrator relayed there was not documentation regarding the delay in the start of home health care. 410 IAC 17-14-1(a)(1)(A)			
G0520	5 calendar days after start of care 484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.	G0520	**ACTIONS TAKEN:** Administrator educated staff regarding need for all ordereddisciplines to complete comprehensive assessment of patient within 5 calendardays. Agency scheduler has been educated to schedule all	2025-01-17

	Based on record review and interview the agency failed to ensure the comprehensive assessment was completed no later than 5 calendar days after the start of care for 1 of 1 patient with a home visit observation of PT services, and with a referral for OT and home health aide services, and diagnosis of a dementia. (Patient 4) The Findings Include: The clinical record for Patient 4, included a referral dated 12/4/2024 that requested PT and OT evaluations. The record failed to evidence an OT evaluation was conducted until 12/14/24. During an interview on 12/18/24 beginning at 2:10 PM, the CM indicated there was no documentation related to the reason for the delay in the evaluation or completion of the comprehensive assessment.		disciplines withinfive calendar days unless there are documented circumstances and provider is notified. Education included a verbal presentation and printed handoutof material. **Responsible Person:** HomeHealth Administrator **Completed:** 1/17/2025 **PREVENTRECURRANCE:** The Quality Coordinator will audit new patient start of carecharts for compliance with completion of comprehensive assessment within fivecalendar days. Quality Coordinator will report findings to Home HealthAdministrator. **Responsible Person:** HomeHealth Administrator **Goal**: 100%	

			Completed: Auditingwas initiated 1/16/2025. Auditing will continue until 100% compliance ismaintained for 3 consecutive months. At that point, auditing may be reduced torandom review (10% of total patient census per quarter or minimum of 30 charts).	
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 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 and interview the agency failed to evidence a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy for 3 of 4 patients with severe interactions. (Patient 2, 4, 6)	G0536	**ACTIONS TAKEN:** The Administrator worked with the Quality Coordinator torevise *Medication Administration andOversight Policy* to clarify directives to staff: clinician to reviewall ordered medications to identify any potential adverse effects or drugreactions. The clinician will thencontact physician/provider to report. The patient will be educated regarding potential adverse effects orinteractions. Administrator educated staff regarding thisprocess/procedure. Education included a verbal presentation and printed handoutof material. **Responsible Person:** HomeHealth Administrator	2025-01-17

	The Findings Include: 1.The record for Patient 4 included a SOC comprehensive assessment, dated 12/6/2024, which revealed medications were reconciled with no serious interactions identified during the comprehensive assessment. The drug interaction report indicated major interactions between Patients' atorvastatin (a medication used to treat high cholesterol) and grapefruit juice. The record failed to evidence education and or an assessment of Patient of the major drug interaction. During an interview on 12/18/24 beginning at 2:10 PM, the clinical supervisor indicated the record did not include documentation that the patient or provider was notified of the drug interaction. 2.The record for Patient 6 included a resumption of care comprehensive assessment, dated 11/24/24, which revealed medications were reconciled with no issues found during the assessment. The drug interaction report indicated major interactions between		**Completed:** 1/17/2025 **<u>PREVENTRECURRANCE:</u>** Quality coordinator to audit 100% of Start of care,Resumption of care and recertification charts for compliance. QualityCoordinator will report findings to Home Health Administrator. **Responsible Person:** HomeHealth Administrator **Goal:** 100% **Completed:** Auditingwas initiated 1/16/2025. Auditing will continue until 100% compliance ismaintained for 3 consecutive months. At that point, auditing may be reduced torandom review (10% of total patient census per quarter or minimum of 30 charts).	

	medication used for the treatment of dandruff) and dofetilide (a medication used for the treatment of irregular heart rate) and furosemide (high blood pressure and body fluid buildup) and dofetilide (a medication used for the treatment of irregular heart rate). The record failed to evidence notification to the patient or provider of the major drug interactions. During an interview on 12/18/24 beginning at 9:45 AM, the clinical supervisor indicated the record did not include documentation that the patient or provider was notified of the drug interaction. 1. The agency policy titled 'Clinical Records – Documentation,' revised 6/2024, indicated each patient clinical record will contain information on medication including adverse drug reactions. 2. The clinical record of Patient #2 included an initial POC dated 11/7/2024 to 1/5/2024 with a primary diagnosis of diabetic foot ulcers (wounds) and SN visits twice a week for eight weeks and PT visits.			

	Documentation dated 11/23/24 indicated Patient was treated at the emergency department for leg cramps that included a new prescription for cyclobenzaprine (muscle relaxant) every 8 hours for three days. SN visit was documented 11/25/2024. Patient's home medication list included tramadol, a pain medication. According to drugs.com, there are major interactions between cyclobenzaprine and tramadol. The clinical record failed to evidence a review of medication interactions with the new prescription nor the notification of the physician regarding the new prescription interactions with Patient's home medications. During an interview on 12/18/2024 beginning at 10:00 AM, Administrator relayed the medication was entered in the electronic medical record but there was no record of interactions documented in the record. 410 IAC 17-14-1(a)(1)(B)			
G0572	Plan of care	G0572	**ACTIONS TAKEN:**	2025-01-17

	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 observation, record review, and interviews the agency failed to ensure each patient received the home health services that were written in the individualized plan of care that identified measurable outcomes and goals in 4 of 12 active clinical records reviewed (Patients # 2, 3, 13, and 14). Findings include: 1 .The clinical record for Patient #2 revealed an initial POC dated 11/7/2024 to 1/5/2024 for SN visits twice a week for eight weeks and PT services once a week for one week, three times a week for four weeks, then twice week for 2 weeks. Care week one indicated a PT evaluation was completed on 11/8/2024, care week two included PT visits on		The Administrator worked with Quality Coordinator to revise *Plan of Care Policy* and *Staff Documentation/Missed Visit Policy*to provide clear directives and steps to follow for ensuring plan of care andvisits are carried out per physician orders. Administrator educated staff regarding informing patient andfamily of ordered visit frequency by each discipline and to discuss and planthe visit schedule with patient. Staff was also educated regarding process forattempts to reschedule visits if the patient has a scheduling conflict andabout the need to notify physician and patient of missed visits before theyoccur. Education included a verbal presentation and printed handout ofmaterial. Reminded staff to utilize dry erase calendar provided inpatient home care admission folder to document visit schedule for patient. **Responsible Person:** HomeHealth Administrator **Completed:** 1/17/2025	

	11/14/2024, care week three include PT visits on 11/18/2024 and 11/19/2024, care week four included a PT visit on 11/26/2024, and care week five included a PT visit on 12/4/2024. The clinical record failed to evidence PT visits were provided to Patient as ordered (three times a week for week 2, 3, 4, and 5); the clinical record failed to evidence the attending physician was notified that the agency was not able to provide services as were ordered. During an interview on 12/16/2024 beginning at 3:00 PM, CM relayed she did not know the reason for visits not conducted as ordered nor was there documentation that the physician was there evidence of a change in the ordered frequency of the visits to be made. 2 .The clinical record for Patient #3 revealed an initial POC dated 11/29/2024 to 01/27/2024 for PT services once a week for one week, three times a week for two weeks, then twice a week for two weeks. The record included documentation, dated 12/2/2024 by PT 1, that a visit was missed due to Patient had a		**PREVENT RECURRANCE:** Quality coordinator will audit for compliance with providingvisits per frequency and in compliance with orders on plan of care. QualityCoordinator will report audit findings to Administrator. **Responsible Person:** HomeHealth Administrator **Goal**: 100% **Completed:** Auditing of visit frequency per plan of care was initiatedon 1/10/25. Auditing will continueuntil 100% compliance is maintained for 3 consecutive months. At that point,auditing may be reduced to random review (10% of total patient census perquarter or minimum of 30 charts).	

	physician appointment. The clinical record failed to evidence documentation of attempts to reschedule an meet the frequency ordered. During an interview on 12/16/2024 beginning at 3:00 PM, CM relayed there was no documentation of attempts to reschedule the ordered visit frequency. 3. The clinical record for Patient #13 included an initial POC dated 11/14/2024 to 01/12/2024 with SN visits once a week for one week then twice a week for four weeks and HHA services twice a week for four weeks. An order for a change in frequency of SN visits, dated 11/25/24, indicated SN visits increased to three times a week for eight weeks. SN visits were documented for November 17, 20, and 22, 2024. The record failed to evidence an order for the SN visits and services for the week of 11/17/24. During an interview on 12/18/2024 beginning at 10:30 AM, CM relayed there were no orders for the skilled care provided for the week of 11/14/2024 to 11/21/2024 nor			

	an order for the frequency increase of SN visits until 11/25/2024. 4. The clinical record for Patient #14 included a POC dated 11/14/2024 to 01/12/2024 with services ordered for SN visits once a week for one week, two visits a week for 8 weeks, then once visit for 1 day and HHA visits twice a week for eight weeks. The clinical record revealed a SN visit was missed on 11/29/2024, indicated Patient needed a different time for the visits. The record evidenced a SN visit was missed visit on 12/3/2024 that indicated Patient did not answer the phone. The clinical failed to evidence documentation of attempts to reschedule the SN visits. The clinical record failed to evidence Patient was seen by a SN from 11/26/2024 to 12/06/2024, a period of 10 days. During an interview on 12/17/2024 beginning at 2:15 PM, CM relayed there was no documentation to attempt rescheduling Patient's SN missed visits. 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 or allowed practitioner may choose to include. Based on record review and interviews the agency failed to	G0574	**ACTIONS TAKEN:** The Home Health Administrator worked with EPIC /IT Analystto ensure infection status is integrated into referral/intake process and flowsto patient record. Home Health Administrator provided education to all staffregarding all required elements on a patient's individualized plan of care. Educationincluded a verbal presentation and printed handout of material. Education specifically addressed requirement and processfor: any ordered/applicable infectioncontrol/transmission based precautions, any care/treatments/precautions relatedto care of the patient including other care agencies (and schedule) providingcare. **Responsible Person:** HomeHealth Administrator **Completed**: 1/17/2025	2025-01-17

	ensure the individualized plan of care included all required elements in 6 of 12 active clinical records reviewed (Patients # 1, 2, 9, 13, 14, and 15). 1. The clinical record for Patient #1 revealed a POC dated 11/10/2024 to 01/08/2024 for SN services twice a week for nine weeks. Patient diagnoses include a chronic ulcer (open sore) of the right and left lower leg with SN to provide wound care to the right and left lower leg 2 times a week. The record included documentation that Patient was in contact precautions (infection control measures used to prevent the spread of infection) for methicillin-resistant Staphylococcus aureus (MRSA, a bacteria resistant to certain antibiotics). The MRSA documentation indicated a gown, gloves and eye protection should be used when entering		**PREVENTRECURRANCE:** Quality coordinator to perform chart audits to monitorcompliance. Quality Coordinator will inform Administrator of audit findings. **Responsible Person:** HomeHealth Administrator **Goal:** 100% **Completed:** Auditing of patient plans of care began on 1/10/25. Auditingwill continue until 100% complianceis maintained for 3 consecutive months. At that point, auditing may be reducedto random review (10% of total patient census per quarter or minimum of 30charts).	

	Patient's room. The clinical record included documentation from Entity D, a wound care clinic. The POC failed to evidence the wound care clinic that treated Patient, nor the wound clinic schedule for treatments, nor the infection control precautions to be taken, related to the MSA infection, during patient care. 2. The clinical record for Patient #2 included an initial POC dated 11/7/2024 to 1/5/2024 for SN and PT services and included the primary diagnoses as diabetic foot ulcers. The clinical record included documentation that Patient was in contact precautions (infection control measures used to prevent the spread of infection) for methicillin-resistant Staphylococcus aureus (MRSA, a bacteria resistant to certain antibiotics). The MRSA documentation indicated a gown, gloves and eye protection should be used when entering Patient's room. The POC failed to evidence MRSA documentation nor personal protective equipment required to wear during the provision of			

	Patients' care. The SOC initial comprehensive assessment, dated 11/7/2024, included notation that Patient attended hemodialysis three times a week (on Monday, Wednesday, and Friday) and had an arteriovenous fistula [AVF] (surgically placed connection of artery and vein for hemodialysis) to the left arm. The National Kidney Federation indicated an AVF limb should be protected from blood pressure cuffs, needle sticks, injury, or anything causing pressure to the limb. The POC failed to evidence the dialysis facility nor Patients dialysis schedule, nor safety measures for protection and care of the AVF. During an interview on 12/16/2024 beginning at 3:00 PM, CM relayed the POC did not include the dialysis facility Patient received hemodialysis [HD] treatments, nor safety measure for their AVF. 3. During an interview on 12/16/2024 beginning at 3:00			

	2's MRSA infection information was in the electronic medical record, however the information did not flow to the POC. 4. The clinical record for Patient #13 included an initial POC dated 11/14/2024 to 01/12/2024 with SN and HHA services. Patient's primary diagnosis was stage 4 pressure ulcer (severe sore extending through skin layers, exposing muscle, tendon or bone) of the left hip with SN to provide wound care every 3 days. The clinical record included documentation from Entity D, a wound care center, dated 11/26/2024 and 12/10/2024. The POC failed to evidence the wound care center nor Patient's schedule for wound care from Entity D. During an interview on 12/18/2024 beginning at 1:20 PM, Other E, the nurse at the wound care clinic, Entity D, revealed Patient #13 was scheduled at the clinic weekly for wound care. During an interview on 12/18/2024 beginning at 10:30 AM, Administrator relayed the POC did not include the wound			

	schedule. 5. The clinical record of Patient #15 included POC dated 10/22/2024 to 12/20/2024 and included a wound assessment at Patients' hemodialysis access site, a central venous catheter [CVC] (a flexible tube in the chest for access to blood for hemodialysis). According to the National Institute of Health, the care of HD CVC should include routine inspection and dressing changes. The POC failed to evidence Patient's dialysis facility, schedule, nor the care and safety of the hemodialysis catheter and who completed the CVC care. During an interview12/17/2024 at 11:00 AM, Other B, family member of Patient #15, relayed Patient had the CVC in their chest for a few months; they indicated Patient attended dialysis three times a week on Monday, Wednesday, and Friday at Entity C. During an interview on 12/18/2024 beginning at 10:30 AM, CM relayed the dialysis schedule nor dialysis facility was included in the POC. CM relayed			

	safety nor care for the CVC. 6. The clinical record for Patient #9 included included an OT evaluation dated 11/8/2024 that indicated OT visits were planned once a week for four weeks. The POC dated 11/01/2024 to 12/30/2024 failed to include the OT services, treatments, and goals. During an interview on 12/17/2024 beginning at 2:15 PM, CM relayed the OT was not included in the POC because the evaluation was completed after the initial evaluation, the POC was not revised to include the OT services. 7. The clinical record for Patient #14 included PT visit documentation dated 11/22/2024, 11/26/2024, 11/29/2024, 12/02/2024, 12/11/2024, 12/12/2024, and 12/16/2024. The POC dated 11/14/2024 to 01/12/2025 failed to include the PT services, treatments, and goals.			

	During an interview on 12/17/2024 beginning at 2:15 PM, Administrator relayed the PT visits started after the POC beginning 11/14/2024 and the POC was not revised. 410 IAC 17-13-1(a)(1)(B), 17-13-1(a)(1)(D)(ii, iii, x)			
G0576	All orders recorded in plan of care 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. Based on record review and interview the agency failed to ensure all patient care orders including verbal orders were recorded in the plan of care in 2 of 12 active clinical records reviewed (Patients #2 and 14). Findings include: 1. The clinical record for Patient #2 included an initial POC dated 11/7/2024 to 1/5/2024 for SN and PT services. An OT evaluation was documented on 11/20/2024 with another OT visit documented on 12/3/2024 and 12/10/2024. The POC failed to include OT schedules, services, treatments, nor goals.	G0576	**ACTIONS TAKEN:** The administratoreducated staff regarding need for all ordered disciplines to be scheduled forinitial evaluation within first 5 days of care. The administrator educated RNCase managers about the need for all orders and disciplines to be included inplan of care and the plans of care to be updated/revised if new orders areadded. Education included a verbal presentation and printed handout of material. **Responsible Person:** HomeHealth Administrator **Completed:** 1/17/2025 **PREVENTRECURRANCE:**	2025-01-17

	During an interview on 12/16/2024 beginning at 3:00 PM, Administrator relayed the OT evaluation was completed after the SOC date so it was not included in the POC nor was the POC revised to include OT services. 2. The clinical record for Patient #14 included documentation of PT visits dated 11/22/2024, 11/26/2024, 11/29/2024, 12/02/2024, 12/11/2024, 12/12/2024, and 12/16/2024. The POC failed to include PT services, treatments, and goals. During an interview on 12/17/2024 beginning at 2:15 PM, Administrator relayed the PT visits started after the POC start date of 11/14/2024 and the POC was not revised.		RN Case Managers will update the patient's plan of care andmonitor for new orders to be added. Quality coordinator to perform chart auditsto monitor compliance. Quality Coordinator will inform Administrator of auditfindings. **Responsible Person:** Home Health Administrator **Goal:** 100% **Completed:** Auditing was initiated on 1/16/25.Auditing will continue until 100% compliance is maintained for 3 consecutivemonths. At that point auditing will be reduced to random review (10% of totalpatient census per quarter or minimum of 30 charts).	
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 record review and interview the agency failed to ensure drugs, services, and treatments were administered only as ordered by a physician in 9 of	G0580	**ACTIONS TAKEN:** Administrator worked with Quality Coordinator to review andrevise agency *Comprehensive Assessment Policy and Plan of Care Policy* to reflect directive for authorized staff tocontact primary care provider to obtain specific verbal orders for drugs,	2025-01-17

	12 active clinical records reviewed (Patients # 2, 3, 5, 6, 7, 13, 14, 16, and 17) and 4 of 5 closed clinical records reviewed (Patients #8, 9, 10, and 11). Findings include: 1.The clinical record for Patient 5 included a referral, dated 11/1/2024, to evaluate for home health services. The record evidenced an OT evaluation was conducted, dated 11/18/2024, and an OT visit was conducted on 12/2624 to discharge patient from OT services. The record failed to evidence an order for OT services. The POC for the certification period 11/20/24 to 01/5/2024 failed to evidence an order for the OT services provided. During an interview on 12/18/24 beginning at 3:50 PM, the CS indicated they had an order written for OT, it was discontinued on 11/19/24. The CS further indicated there was no order for the OT services provided. 2. An observation of an initial skilled visit, on 12/17/2024 beginning at 9:45AM, established the SOC for Patient 7; Patient was wheelchair		treatment and care rendered. Administrator educated staff onneed to obtain appropriate physician/provider order(s) for all drugs, care/services, and treatments rendered. Education included a verbal presentation and printed handout ofmaterial. **Responsible Person:** HomeHealth Administrator **Completed:** 1/17/2025 **<u>PREVENTRECURRANCE:</u>** RN case managers to monitor for verbal orders for all careincluding drugs, services and treatments as part of the plan of care. Qualitycoordinator to monitor ongoing compliance through chart audits. **Responsible Person**: Quality Coordinator **Goal:** 100% **Completed:** Auditingwas initiated on 1/16/25. Auditing will continue until 100% compliance ismaintained for 3 consecutive months. At that	

	bound, paraplegic (a person who does not have functional use of their legs) with neurogenic bladder (the nerves and muscles do not control the bladder). The referral revealed Patient required catheter care. During the visit observed RN 2 anchored a 20 French foley catheter, filled the balloon with 30 ml normal saline. The record failed to evidence an order for the catheter change, nor the skilled care provided during the visit. During an interview on 12/18/24 beginning at 3:00 PM, the CS indicated they did not have an order from the provider as to what size and type of catheter to use nor the amount to fill the balloon. 3. During a home visit observation for Patient 6 on 12/17/24 beginning at 11:00 AM, RN 4 performed pleural drain care, including draining of pleural fluid. During the procedure, it was observed that the nurse continued to drain fluid until the patient reported significant pain. RN 4 then clamped the drain, measured 325 ml fluid had drained and covered Patient 6 drain site with		torandom review (10% of total patient census per quarter or minimum of 30charts).	

	a clean dressing. The record for Patient 6 included a resumption POC, dated 11/24/24 for the certification period 11/09/2024 – 01/07/2025. The POC and clinical record failed to evidence the procedure for pleural drain care, nor minimum or maximum amounts for fluid drainage, during the procedure. During an interview on 12/18/24 beginning at 9:45 AM, the CS indicated the interventions for pleural drain care including the minimum and maximum amount for fluid drainage were on the previous POC, though were discontinued on 11/12/24 and should not have been. 4. The clinical record for Patient #2 revealed SN visit notes documented for 11/7/2024 for the SOC, and on 11/9/2024; PT visits were documented for 11/12/2024, 11/13/2024, and 11/14/2024. The clinical record failed to evidence orders were obtained from the attending physician, documented prior to the provision of care, for the skilled care that began on 11/7/2024 to 11/18/2024.			

	During an interview, on 12/16/2024 beginning at 3:00 PM, the Administrator relayed there was not an order obtained from the attending for the skilled care provided, prior to 11/18/2024. 5. The clinical record for Patient #3 revealed PT services began on 11/29/2024 the SOC, then continued during week 2 and week 3 of the certification period. The clinical record failed to evidence orders were obtained from the attending physician, documented prior to the provision of care, for the skilled care that began on 11/29/2024 to 12/10/2024. During an interview on 12/18/2024 beginning at 2:00 PM, CM relayed there was no documentation of an order for the skilled care provided, prior to the signing of the POC on 12/10/2024. 6. The clinical record for Patient #8 revealed SN services began with the SOC on 8/25/2024 and continued weekly through the certification period ending 10/22/2024. The clinical record failed to evidence orders for			

	the attending physician and documented, prior to the provision of care, beginning on 8/25/2025 to 9/10/2024. Patients POC was not signed until 9/10/2024. During an interview on 12/18/2024 beginning at 2:30 PM, Administrator relayed there was not an order for the skilled care provided until the POC was signed on 9/10/2024. 7. The clinical record for Patient #9 revealed documentation of PT visits, dated 11/5/2024, 11/7/2024, and 11/14/2024 and an OT evaluation dated 11/8/2024. The POC was signed by the physician 11/14/2024. The clinical record failed to evidence orders for the skilled care were obtained from the physician, prior to the provision of care, provided beginning on 11/1/2024 to 11/14/2024. During an interview on 12/17/2024 beginning at 2:15 PM, CM relayed the referral dated 10/29/2024 requested PT and OT services; the administrator indicated the record did not include specific orders for the skilled care			

	signed on 11/14/2024. 8. The clinical record for Patient #10 included PT visits were documented, dated 09/17/2024, 09/19/2024, and 10/01/2024. The clinical record failed to evidence orders for the skilled care were obtained from the attending, prior to the provision of care and documented, for the skilled care provided from 9/17/2024 to 10/02/2024. During an interview on 12/18/2024 beginning at 10:30 AM, Administrator relayed there are no orders for the skilled care provided until the POC was signed on 10/02/2024. 9. The clinical record for Patient #11 revealed SN care was provided, including wound care documented at the SOC, 9/21/2024, and subsequent visits on 9/25/2024 and 9/27/2024. The clinical record failed to evidence orders for the skilled care provided, were obtained from the attending physician, prior to the provision of care, for the skilled care provided beginning 9/21/2024 to 10/08/2024. During an interview on			

	12/18/2024 beginning at 10:30 AM, Administrator relayed the record failed to evidence documentation of an order for the care provided beginning on 9/21/2024 to 10/8/2024. 10. The clinical record for Patient #13 revealed documentation of HHA visits dated 11/18/2024 and 11/20/2024 and SN visits dated 11/14/2024 and 11/20/2024. The clinical record failed to evidence documentation of an order was obtained from the attending physician, prior to the provision of care, for the services provided from 11/14/2024 to 11/21/2024. During an interview on 12/18/2024 beginning at 10:30 AM, CM relayed the clinical record failed to evidence documentation of orders, obtained from the attending, for the care which began on 11/14/2024 to 11/21/2024. 11. The clinical record for Patient #14 revealed the SOC was 9/15/2024, when skilled services began, and and continued weekly through the certification period. The clinical			

	order for the skilled nurse services was obtained from the attending physician for the skilled care provided from 9/15/2024 to 9/26/2024. The record revealed a PT initial evaluation, dated 11/22/2024 with subsequent PT visits on 11/26/2024, 11/29/2024, 12/02/2024, 12/11/2024, 12/12/2024, and 12/16/2024. The clinical record failed to evidence orders for the PT services that began on 11/22/2024. During an interview on 12/17/2024 beginning at 2:15 PM, Administrator relayed there was not an order for PT services, that began on 11/22/2024 nor orders for the skilled nurse services from 9/15/2024 to 9/26/2024. 12. The clinical record for Patient #16 revealed SN visits that documented skilled care, and included urinary catheter issues, were documented and dated 12/05/2024 and 12/10/2024. The clinical record failed to evidence documentation of verbal orders, nor written orders for the skilled care provided from 11/25/2024			

	to 12/18/2024. During an interview on 12/18/2024 beginning at 10:30 AM, Administrator relayed there were no orders obtained for the skilled services provided, that began on 11/25/2024 until the physician signed the POC on 12/18/2024. 13. The clinical review on 12/17/2024 for Patient #17, revealed a SOC comprehensive assessment dated 12/10/2024, and subsequent SN visit on 12/14/2024; the record revealed a PT evaluation dated 12/11/2024 and subsequent PT visits on 12/12/2024 and 12/13/2024. On 12/17/2024, the clinical record failed to evidence a POC. The clinical record failed to evidence documentation of a verbal order, nor written orders for the skilled care provided. During an interview on 12/17/2024 beginning at 2:15 PM, the Administrator relayed the POC was not in the clinical record nor was there documentation of verbal orders for the care provided. During a subsequent interview on			

	AM, the Administrator revealed the POC was sent to the physician by Other A, a case manager on 12/17/2024. During an interview on 12/18/2024 beginning at 9:35 AM, Other A relayed the POC for Patient #17 was created and sent to the physician on 12/17/24 at 3:45 PM. 410 IAC 17-13-1(a)			
G0644	Program data 484.65(b)(1),(2),(3) Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. Based on record review and interviews, the agency failed to ensure the Quality assessment and Performance Improvement (QAPI)	G0644	**ACTIONS TAKEN:** The Administrator and Quality Coordinator reviewed currentand recent patient outcome/OASIS data to identify high risk, high volume,problem prone areas to develop agency QAPI program for 2025. The Home HealthAdministrator presented agency QAPI program to Governing Body during meeting on1/6/25. The QAPI program was approved and accepted by the governing body. The Administrator educated staff regarding QAPI program andidentified areas for improvement including a Performance Improvement Plan forpatient falls. Education	2025-01-17

	from Outcome Assessment and Information Set (OASIS) to monitor quality of care and failed to ensure the detail and data collection was approved by the agency's governing body in 1 of 1 agency. Findings include: The review of agency QAPI documents dated 1/1/2024 to 9/30/2024 included data collections of medication reconciliation, patient falls, and central line associated bloodstream infections with quarterly data collections. The QAPI documents failed to evidence the agency included their OASIS data and failed to evidence their Governing Body approved their detail and data collection. During an interview on on 12/18/2024 beginning at 11:45 AM, Administrator relayed OASIS data was not used for QAPI. She revealed the governing body did not approve nor was the governing body involved in the QAPI program. 410 IAC 17-12-2(a)		included a verbal presentation and printed handout ofmaterial. **Responsible Person:** HomeHealth Administrator **Completed**: 1/17/25 The Home Health Administrator and Quality Coordinator willcollaborate to continue data analysis and QAPI program activities. Home HealthAdministrator to report QAPI program progress/findings quarterly to governingbody in addition to reporting at department staff meetings. **PREVENT RECURRANCE:** **Responsible Person:** HomeHealth Administrator **Goal:** 100% **Completed:** Surveillanceof QAPI program will continue on an ongoing basis.	

G0646	Program activities 484.65(c) (1) The HHA's performance improvement activities must (i) Focus on high risk, high volume, or problem-prone areas; (ii) Consider incidence, prevalence, and severity of problems in those areas; and (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. Based on record review and interview the agency failed to ensure the performance improvement activities included high risk, high volume, or problem prone areas and lead to an immediate correction of an identified problem that directly affects the health and safety of patients in 1 of 1 agency. Findings include: The review of agency QAPI documentation revealed the agency noted six patients reported falls during January, February, and March of 2024, five patients with falls during April, May, and June of 2024, and 13 patients reported falls during July, August, and	G0646	**ACTIONS TAKEN:** The Administrator and Quality Coordinator reviewed current and recent patientoutcome/OASIS data to identify high risk, high volume, problem prone areas todevelop agency QAPI program for 2025. Patient falls have been identified as ahigh volume, problem prone area. A falls Performance Improvement Plan has beeninitiated. The Administrator educated staff regarding QAPI program andidentified areas for improvement including a Performance Improvement Plan forpatient falls. Education included a verbal presentation and printed handout ofmaterial. Staff was educated regarding use of CDC patient safetybrochure for patient education. **Responsible Person:** HomeHealth Administrator	2025-01-17

	included raw data, did not include percentages from the agency's current census. The QAPI documentation failed to evidence that the raw data, the agency collected, was reviewed and analyzed to determine if an immediate intervention was warranted, ending with their 3rd quarter, 9/30/3034. During an interview on 12/18/2024 beginning at 11:25 AM, Administrator relayed the QAPI fall results were reported to their safety committee, on 12/4/2024. She revealed there were no documentation, no immediate interventions regarding the increase in falls and no further documentation was provided prior to exit.		**Completed**: 1/17/2025 **<u>PREVENTRECURRANCE:</u>** **Responsible Person:** HomeHealth Administrator **Goal:** 100% **Completed:** Administrator and Quality Coordinator initiated use of CDCPatient Safety printed materials for distribution and education of patients.Staff was educated on materials on 1/16/2025 and 1/17/2025. Auditing was initiated on 1/16/25. Auditing of all patientrecords for completed fall risk assessment and appropriate fall riskinterventions on plan of care will be completed by quality coordinator**.** Auditing will continue until 100%compliance is maintained for 3 consecutive months. At that point auditing willbe reduced to random review. Auditing of all patient falls will be completed byAdministrator to determine if additional	

			Auditingwill continue on an ongoing basis.	
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 accepted standards for infection prevention were followed to prevent the transmission of infections and communicable diseases in 4 of 7 active clinical records reviewed with a home visit (Patients #1, 2, 4, 6). Findings include: *During a home visit observation on 12/16/24 beginning at 11:40 AM for Patient 4, PT 2 was observed taking vital signs of Patient 4 and placing the soiled equipment onto a barrier. It was observed near the end of the visit, PT 2 wiped equipment with a sanitizing wipes and gloved PT 2 had worn throughout the	G0682	**<u>ACTIONS TAKEN</u>:** The Administrator educated all staff regarding infectioncontrol practices including standard precautions and transmission basedprecautions. Staff was educated on how this should be included in the patientplan of care as appropriate. Hand hygiene, PPE use and bag technique andequipment sterilization was reviewed with staff. Education included a verbalpresentation and printed handout of material. **Responsible Person:** HomeHealth Administrator **Completed:** 1/17/2025 **<u>PREVENTRECURRANCE:</u>** Clinical supervisor will perform a supervisory visit on allclinical field staff within 30 days to observe hand hygiene, PPE use andcompliance with	2025-01-17

	visit while providing care to Patient 4. PT 2 placed equipment back on the soiled barrier to allow to dry. During an interview on 12/16/24 beginning at 12:00 PM, PT 2 indicated they should have used a second barrier to place the clean equipment on to allow to dry. During an interview on 12/16/24 beginning at 2:10 PM the CS indicated it was not standard practice to use the same gloves to sanitize equipment that were used for patient care, nor is it standard practice to place sanitized items on a soiled barrier to allow to dry. *During a home visit observation on 12/17/24 beginning at 11:00 AM for Patient 6, it was observed RN 4 was performing a sterile procedure of plural drain care. During the procedure it was observed RN 4 removed sterile gloves turning them out as they removed the gloves, placed them on a barrier that laid on the bed and performed hand hygiene. RN 4 then retrieved an		standard/transmission based precautions and bagtechnique/equipment sterilization. Quality coordinator will audit records for documentation ofinfection control practices on plan of care and in care notes. **Responsible Person:** HomeHealth Administrator **Goal: 100%** **Completed:** Supervisory visits began on 1/10/2025. When 100% complianceis reached, supervisory visits will be performed quarterly. Quality coordinator will audit 100% of plans of care for documentationof required infection control practices. Auditing was initiated 1/16/2025.Auditing will continue until 100% compliance is maintained for 3 consecutivemonths. At that point, auditing may be reduced to random review (10% of totalpatient census per quarter or minimum of 30 charts).	

	alcohol prep pads from the clinician bag and reapplied the gloves they had turned out and placed on the barrier. Once gloves were re-applied, RN 4 continued with pleural drain care. During an interview on 12/17/24 beginning at 11:45 AM, RN 4 indicated they reused the first pair of sterile gloves because they needed to retrieve alcohol prep from the clinician bag and did not have another pair of sterile gloves. RN 4 further indicted they used those gloves because they believed them to be the best option. During an interview on 12/17/24 beginning at 4:00 PM, the CS indicated it is not the accepted practice to reuse any gloves. # The clinical record for Patient #1 revealed a POC dated 11/10/2024 to 01/08/2024 for SN services twice a week for nine weeks. Patient diagnoses include a chronic ulcer (open sore) of the right and left lower leg with SN to provide wound care to the right and left lower leg 2 times a week. The clinical record included documentation			

	that Patient was in contact precautions (infection control measures used to prevent the spread of infection) for methicillin-resistant Staphylococcus aureus (MRSA, a bacteria resistant to certain antibiotics). The MRSA documentation indicated a gown, gloves and eye protection should be used when entering Patient's room. The POC failed to evidence MRSA documentation nor personal protective equipment required to care for Patient. During a home visit observation on 12/13/2024 beginning at 9:40 AM, RN 1 provided care to Patient that included direct contact for assessment and wound care. RN 1 failed to use a gown and protective eyewear. During an interview on 12/16/2024 beginning at 3:00 PM, CM relayed Patient's MRSA infection information was in the electronic medical record, however the information did not flow into agency documents. # The clinical record for Patient #2 included an initial POC dated 11/7/2024 to 1/5/2024 for SN			

	and PT services and included the primary diagnoses as diabetic foot ulcers. The clinical record included documentation that Patient was in contact precautions (infection control measures used to prevent the spread of infection) for methicillin-resistant Staphylococcus aureus (MRSA, a bacteria resistant to certain antibiotics). The MRSA documentation indicated a gown, gloves and eye protection should be used when entering Patient's room. The POC failed to evidence MRSA documentation nor personal protective equipment required to care for Patient. During a home visit observation on 12/13/2024 beginning at 2:00 PM, OT 1 provided care to Patient that included direct physical contact. OT 1 failed to use a gown or protective eyewear.			

	During an interview on 12/16/2024 beginning at 3:00 PM, CM relayed Patient's MRSA infection information was in the electronic medical record, however the information did not flow into agency documents. 410 IAC 17-12-1(m)			
G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; Based on observation, record review, and interview, the agency failed to ensure each patient received a patient-specific assessment for 1 of 1 start of care with comprehensive assessment observed on 12/17/24. (Patient 7) Findings Include: An observation of an initiation of the comprehensive assessment, on 12/17/24 beginning at 9:45 AM, for Patient 7, a wheelchair bound paraplegic (a person who does not have functional use of their	G0706	**ACTIONS TAKEN:** The Administrator educated all staff regarding completion ofa comprehensive assessment at the start of each episode of care and as needed.Staff was instructed on the need to include all body systems and functionalassessments in order to gather comprehensive data. In addition staff was educated to document thisinformation accurately and timely. Education included a verbal presentation andprinted handout of material. **Responsible Person:** HomeHealth Administrator **Completed:** 1/17/2025	2025-01-17

	(the nerves and muscles do not control the bladder); the assessment established the SOC. RN 2 inserted and anchored a foley catheter and provided catheter care. RN 2 failed to assess Patients' lung sounds, bowel sounds, nor assess Patients' legs nor their feet. During an interview on 12/17/24 beginning at 10:45 AM, RN 2 indicated all body systems are included in the comprehensive assessment at the SOC. RN 2 indicated they did not assess Patient 7s' lungs, bowel sounds, nor their legs and feet. During an interview on 12/17/24 beginning at 4:00 PM, the CM indicated all body systems should be assessed during the comprehensive assessment and that was not done for Patient 7.		**PREVENTRECURRANCE:** Clinical supervisor to complete a supervisory visit on allprofessional clinicians (RN, PT, OT) within 30 days to ensure compliance withcomprehensive assessment and documentation. Clinical Supervisor will reportfindings to Home Health Administrator. **Responsible Person:** HomeHealth Administrator **Goal:** 100% **Completed:** Supervisory visits for comprehensive assessmentbegan 1/10/2025. When 100% compliance is reached, supervisory visits will beperformed quarterly. Quality Coordinator will audit 100% of comprehensiveassessments for completion. Auditing was initiated 1/16/2025. Auditing willcontinue until 100% compliance is maintained for 3 consecutive months. At thatpoint, auditing may be reduced to random review (10% of total patient censusper quarter or minimum of 30 charts).	

G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on observation, record review, and interview, the agency failed to maintain an accurate clinical record for 1 of 1 record reviewed with a SOC of 12/17/24. (Patient 7) The Findings Include: The record was reviewed on 12/18/24 and evidenced documentation that a comprehensive assessment was completed on 12/17/24 by RN 2. The assessment failed to evidence a complete assessment of the respiratory system, included a gastrointestinal assessment indicating the presence of bowel sounds in all quadrants, and included an integumentary assessment which indicated Patient was assessed for skin integrity issues and none were present. During an interview on 12/18/24 beginning at 3:00 PM	G0716	**ACTIONS TAKEN:** The Administrator educated all staff regarding completion ofa comprehensive assessment at the start of each episode of care and as needed.Staff was instructed on the need to include all body systems and functionalassessments in order to be comprehensive and this information should bedocumented accurately and timely. Education included a verbal presentation and printedhandout of material. **Responsible Person:** HomeHealth Administrator **Completed:** 1/17/2025 **PREVENTRECURRANCE:**	2025-01-17

	observe the RN2 perform a respiratory assessment, gastrointestinal assessment, nor an integumentary assessment and did not know why RN 2 would have documented those assessments.		Clinical supervisor to complete a supervisory visit on allprofessional clinicians (RN, PT, OT) within 30 days to ensure compliance withcomprehensive assessment and documentation. Clinical Supervisor will reportfindings to Home Health Administrator. **Responsible Person:** HomeHealth Administrator **Goal:** 100% **Completed:** Supervisoryvisits for comprehensive assessment began 1/16/2025. When 100% compliance isreached, supervisory visits will be performed quarterly. Quality Coordinatorwill audit 100% of comprehensive assessments for completion. Auditing wasinitiated 1/16/2025. Auditing will continue until 100% compliance is maintainedfor 3 consecutive months. At that point, auditing may be reduced to randomreview (10% of total patient census per quarter or minimum of 30 charts).	

G0808	Onsite supervisory visit every 14 days 484.80(h)(1)(i) (1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech language pathology services (A) A registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in paragraph (g) of this section, must complete a supervisory assessment of the aide services being provided no less frequently than every 14 days; and (B) The home health aide does not need to be present during the supervisory assessment described in paragraph (h)(1)(i)(A) of this section. Based on record reviews and interviews the agency failed to ensure an appropriate skilled professional supervised HHA's no less frequently than every 14 days in 2 of 4 active clinical records with HHA services (Patients # 13, 16). Findings include: 1.The clinical record for Patient #13 evidenced SN services and HHA services were provided during the initial certification period of 11/14/2024 to 01/12/2024; SN visits were	G0808	**ACTIONS TAKEN:** The Home Health Administrator educated staff regardingrequired Home Health Aide supervisory visits performed and documented at leastevery 14 days. Education included a verbal presentation and printed handout ofmaterial. **Responsible Person:** HomeHealth Administrator **Completed:** 1/17/2025 **PREVENTRECURRANCE:** Clinical supervisor will audit all patient plans of care forHome Health Aide services and monitor for compliance. Clinical supervisor willreport findings to Home Health Administrator. **Responsible Person:** HomeHealth Administrator **Goal:** 100% **Completed:** Auditingwas initiated on 1/13/25. Auditing will continue until 100% compliance ismaintained for 3 consecutive months. At that	2025-01-17

	conducted weekly and HHA visits were conducted 2 times per week. The record evidenced a HHA supervisory visit was completed by the SN on 11/22/2024 and not again until 12/09/2024, a period of 17 days. The record failed to evidence supervisory visits of the HHA were conducted every 14 days, at minimum. During an interview on 12/18/2024 beginning at 10:30 AM, CM relayed Patient was seen by SN between the dates of 11/22/2024 and 12/09/2024, though the supervisory information was not documented. 2. The clinical record for Patient #16 revealed a SOC of 3/30/2024 and Patient received skilled nurse services for urinary catheter care and HHA services twice a week through the certification periods dated 9/26/2024 to 11/25/2024 and from 11/26/2024 to date of survey. The record evidenced HHA visits notes, dated 11/05/2024, 11/07/2024, 11/11/2024, 11/13/2024, and 11/19/2024. The record revealed HHA supervisory visits		torandom review (10% of total patient census per quarter or minimum of 30 charts).	

	11/22/24, a period of 24 days between visits. The clinical record failed to evidence a HHA supervisory visits every 14 days, at minimum. During an interview on 12/18/2024 beginning at 10:30 AM, CM relayed the clinical record did not include documentation of the supervisory visits were conducted every 14 days, at minimum. 410 IAC 17-14-1			
N0000	Initial Comments This visit was for a State Re-Licensure Survey of a Home Health Provider. Survey Dates: 12/12/2024 to 12/13/2024 and 12/16/2024 to 12/18/2024 12-month Unduplicated Skilled Admissions: 880 QR: A1 12/31/2024	N0000		

N9999	Final Observations Authority IC 16-27-1.5-5 "Approved dementia training for home health aides" Sec. 5 (a) This section applies to a registered home health aide who: (1) is employed as a home health aide; and (2) provides care to an individual who has been diagnosed with or experiences symptoms of Alzheimer's disease, dementia, or a related cognitive disorder. (b) As used in this section, "approved dementia training" refers to a dementia training program: (1) for use in training home health aides in the care of individuals described in subsection (a)(2); and (2) that has been approved by the state department under subsection (f). (c) Not later than sixty (60) days after the date on which a home health aide is initially hired to care for an individual with Alzheimer's disease, dementia, or a related cognitive disorder, the home health aide shall complete at least six (6) hours of approved dementia training. (d) Before December 31 of each year, a home health aide who has been employed as a home health aide for at least one (1) year shall complete at least three (3) hours of approved dementia training. (e) A home health aide who: (1) has received the training required by subsections (c) and (d); (2) has been employed as a home health aide for at least twenty-four (24) consecutive months; and (3) is hired by a home health agency; is not required to repeat the training required by this section. (f) The state department shall do the following: (1) Identify and approve each dementia	N9999	**ACTIONS TAKEN:** Home Health Administrator educated staff regarding *approved dementia training* requirement fornew Home Health Aides within 60 days of hire. This education included Quality Coordinatorand Clinical Supervisor. Education included a verbal presentation and printedhandout of material. Additional IAHHC (IndianaAssociation for Home and Hospice Care) approved Home Health Aide dementia traininghas been completed to meet regulatory requirement of six hours upon hire andthree hours annually by December 31. **Responsible Person:** HomeHealth Administrator **Completed: 12/30/2024** **PREVENTRECURRANCE:** **Responsible Person:** HomeHealth Administrator	2025-01-17

	training program that meets the following requirements: (A) The dementia training program includes education concerning the following: (i) The nature of Alzheimer's disease, dementia, and other related cognitive disorders. (ii) Current best practices for caring for and treating individuals with dementia. (iii) Guidelines for the assessment and care of an individual with dementia. (iv) Procedures for providing patient centered quality care. (v) The daily activities of individuals with dementia. (vi) Dementia related behaviors, communication, and positive intervention. (vii) The role of an individual's family in caring for an individual with dementia. (B) The dementia training program: (i) must be culturally competent; and (ii) may be provided online. (2) Establish and implement a process for state department approval of a dementia training program. (g) To the extent allowed by 42 CFR 484.80, the hours of approved dementia training completed under this section satisfies an equivalent number of hours of the home health aide training required by 42 CFR 484.80. (h) An entity that provides approved dementia training shall provide to each home health aide who successfully completes the training a certificate of completion. (i) A home health aide: (1) is responsible for maintaining the home health aide's certificate of completion; and (2) may use the certificate of completion as proof of compliance with this section. As added by P.L.44-2022, SEC.1.		**Goal:** 100% **Completed:** HomeHealth administrator will monitor all home health aide personnel and education recordsfor completion of approved (IAHHC) dementia training within 60 days of hire and annualdementia training hours by December 31. Administrator will assign approved education and monitor for completion.Administrator will file documented proof of completion in employee files.Auditing will be performed within 60 days of hire and annually prior to the endof the calendar year.	

Authority IC 16-27-1.5-6 "Conditions required to administer gastrointestinal and jejunostomy tube feedings; training"

Sec. 6 (a) A registered home health aide may administer gastrointestinal and jejunostomy tube feedings to a specific patient only if the following conditions are met:

(1) The registered home health aide has completed the training curriculum described in subsection (b).

(2) A registered nurse, providing registered nursing under IC 25-23-1-1.1(b)(6), either:

(A) supervises the registered home health aide in administering the gastrointestinal and jejunostomy tube feedings; or

(B) delegates responsibility for administering the gastrointestinal and jejunostomy tube feedings to the registered home health aide based on the registered nurse's assessment of the registered home health aide's competency to administer gastrointestinal and jejunostomy tube feedings.

(3) The home health agency that the registered home health aide is employed with:

(A) allows the registered home health aide to administer gastrointestinal and jejunostomy tube feedings;

(B) establishes a procedure for:

(i) the delegation of the administration of gastrointestinal and jejunostomy tube feedings from a registered nurse to a registered home health aide that includes patient specific clinical parameters based on the registered nurse's assessment of the patient and the registered home health aide's competency to administer the gastrointestinal and jejunostomy tube feedings; and

(ii) the assessment by the registered nurse of the patient specific clinical parameters;

(C) retains documentation that the registered home health aide has completed the training curriculum described in subsection (b); and

(D) notifies each patient requiring gastrointestinal and jejunostomy tube feedings upon admission that the home health aide agency may allow registered home health aides to administer gastrointestinal and jejunostomy tube feedings.

(b) Training curriculum for home health aides to administer gastrointestinal and jejunostomy tube feedings must:

(1) be approved by the state department; and

(2) include the following concerning the administration of gastrointestinal and jejunostomy tube feedings:

(A) At least four (4) hours and not more than eight (8) hours of classroom training.

(B) At least two (2) hours and not more than four (4) hours of practical training.

(C) A written and practical examination administered by the trainer.

(c) A registered home health aide may not administer gastrointestinal and jejunostomy tube feedings until the home health aide has successfully:

(1) completed the curriculum described in subsection (b); and

(2) passed the examinations described in subsection (b)(2)(C).

(d) The state department may require a registered home health aide who administers gastrointestinal and jejunostomy tube feedings under this section to annually complete not more than one (1) hour of in service training specific to the administration of gastrointestinal and jejunostomy tube feedings.

(e) Before January 1, 2024, the state department must approve at least one (1) training curriculum described in subsection (b).

As added by P.L.117-2023, SEC.6.

Based on record review and interview the agency failed to ensure at least 6 hours of dementia training was provided in the first 60 days of hire in 1 of 2 HHA personnel records reviewed (HHA #1).

Findings include:

The record for Patient 4 revealed a diagnosis of dementia. Documentation indicated home health aide visits were made on 12/12/24 and 12/13/24 by HHA 1 for Patient 4.

The personnel record of HHA 1 was reviewed and revealed a hire date of 8/5/2024; the record failed to evidence 6 hours of dementia training was completed.