STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157067	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER The Center for Hospice and Palliative Care Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE, MISHAWAKA, IN, 46545	

(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: June 2, 3, 4, 5, 6, 9, 2025 Active Census: 0 At this Emergency Preparedness survey, The Center for Hospice and Palliative Care Inc was found to be 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 Re-Licensure survey of a Home Health Provider. Survey Dates: June 2, 3, 4, 5, 6, 9, 2025 12-Month Unduplicated Skilled Admissions: 0 A Fully Extended Survey was announced to CM on 6/06/2025 at 3:05 PM. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.	G0000		

	Abbreviations: RN - Registered Nurse, LPN - Licensed Practical Nurse, CM - Clinical Manager, SN - Skilled Nurse, POC - Plan of Care, SOC - Start of Care, EMR - Electronic Medical Record, ROC - Resumption of Care QR 6/16/2025 A2			
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. Based on record review and interview, the home health agency failed to ensure an occupational therapy (OT) evaluation was conducted within 5 days of SOC for 1 of 1 records reviewed of a patient referred to the agency for OT (Patient #2). Findings include: 1. Patient #2 s clinical record indicated Patient was referred to the agency on 2/21/2024. A communication note, dated 2/21/2024, evidenced Patient was referred for SN, physical therapy, OT, and speech	G0520	**1 How are you going to correct thedeficiency? If already corrected, include the following steps and state date ofcorrection.** **Action:** Training and education will be provided tostaff and contracted staff on the importance of timely assessments and policyrequirements. **Responsible person:** Clinical Educator **Completed date: by7/9/25** **2 How are you going to prevent thedeficiency from recurring in the future?** **Action:** Audit100% of future home health patient charts for compliance with timelyassessments. Ongoing 25 patient charts or 25% of daily census(whichever is greater) will be audited weekly. The threshold is 100%. Whenthreshold has been met for 4 consecutive weeks, will reduce audits to	2025-07-09

	therapy. Patient s SOC was 2/28/2024 and an OT evaluation was conducted on 3/08/2024, which was nine days after the SOC. The record failed to evidence Patient was notified and agreeable to the delay in OT evaluation. During an interview on 6/05/2025 beginning at 3:15 PM, RN 3 reported she thought there was a miscommunication among Entity F, a contracted outpatient therapy provider, staff regarding who was going to conduct the OT evaluation. The nurse stated Patient was aware and agreeable to delay in the evaluation, however the record failed to evidence this notification. During an interview on 6/09/2025 beginning at 9:42 AM, Person E, an employee of Entity F, reported the entity tried to see patients within 48 hours to 5 days of receiving a referral for therapy services. Person E reported the agency received notification of an OT evaluation order on 3/01/2024. Person E was unsure of the reason Patient s OT evaluation was not conducted until		greater) monthly. When thresholdhas been met for 2 consecutive months, will reduce to 10 records or 10% ofdaily census (whichever is greater) quarterly. **Responsible Person:**Director of Quality Assurance	

	entity had documentation that Patient was notified of the delay in evaluation. No further documentation was provided prior to the survey exit.			
G0534	Patient's needs 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review and interview, the home health agency failed to ensure the initial comprehensive assessment included a complete assessment of the patient s health needs for 1 of 1 record reviewed of a patient with a left ventricular assist device and wounds (Patient #1). Findings include: 1. Patient #1 s clinical record evidenced a SOC date of 8/02/2024. Patient was discharged on 8/01/2024 by Entity C, a hospital. Discharge instructions from Entity C included to notify Patient s physician if there was a greater than 2 change in Patient s Left Ventricular Assist Device (LVAD, a pump surgically implanted into the heart to assist with pumping blood) parameter	G0534	1. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** **Action:** Training and education will be provided tostaff on the importance of complete assessments and policy requirements. **Responsibleperson:** Clinical Educator **Completed date: by 7/9/25** **2 2. Howare you going to prevent the deficiency from recurring in the future?** **Action:** Audit 100% of future home health patientcharts for compliance with complete initial assessments. Ongoing 25patient charts or 25% of daily census (whichever is greater) will be auditedweekly. The threshold is 100%. When the threshold has been met for 4consecutive weeks, will reduce	2025-07-09

	readings, including flow, power, and pulsatility index (PI, measures the native contractility of the heart). The discharge instructions also indicated Patient s goal Mean Arterial Pressure (MAP, measurement of the average arterial pressure throughout one cardiac cycle, used to monitor LVAD patients as traditional blood pressure methods may not be accurate) was 65 90 millimeters mercury (mmHg). Former Employee D, an RN, documented an initial comprehensive assessment was completed on 8/02/2024. The visit note indicated Patient had a LVAD and two open wounds, one to the chest and one to the LVAD driveline (portion of the LVAD which connects the pump to the external battery). Both wounds required a wound Vacuum-Assisted Closure (VAC, negative pressure therapy used to help treat wounds). The note failed to evidence an assessment of Patient s LVAD parameters, including the LVAD flow, power, and/or PI, failed to evidence a MAP was obtained, and failed to evidence an assessment of Patient s wounds, including wound bed tissue,		audits to 10 records or 10% of daily census(whichever is greater) monthly. When threshold has been met for 2 consecutivemonths, will be reduced to 10 records or 10% of daily census (whichever isgreater) quarterly. **Responsible Person:** Director of Quality Assurance	

	surrounding skin appearance, wound edges, and presence or absence of drainage, odor, etc. During an interview on 6/04/2025 beginning at 10:14 AM, Former Employee D reported when a patient was admitted to the home health agency with a wound, she would conduct a wound assessment including the color of the wound, presence or absence of slough (dead tissue), drainage, etc. The nurse stated her assessment of Patient s LVAD consisted of listening to Patient s heart and asking Patient if there were any issues with it.			

	During an interview on 6/04/2025 beginning at 2:50 PM, CM reported on admission, the nurse assessment should include all characteristics, including the type of wound, wound surface, presence or absence of tunneling, etc. CM reported the nurse should be assess for LVAD parameters, including the LVAD flow, power, and PI. CM also stated a traditional blood pressure should not be obtained on an LVAD patient as it would not be accurate. 410 IAC 17-14-1(a)(1)(B)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations;	G0574	1. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** **Action:** Training and education will beprovided to staff on the importance of a comprehensive plan of care thatincludes all nursing interventions. **Responsible person:** ClinicalEducator **Completed date: by 7/9/25** **2 2. How are you going to**	2025-07-09

	(viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the home health agency failed to ensure the POC included all nursing interventions for 1 of 2 records reviewed of patients who received more than one SN visit per week. (Patient #1) Findings include: 1. An agency policy Plan of Care: Physician Certification, revised 3/2024, indicated the POC should include An assessment of the patient s needs and identification of services. The scope & of services/disciplines needed in order to meet the patient s/caregiver s needs &. 2. Patient #1 s clinical record		**prevent the deficiency from recurring in the future?** **Action:** Audit 100% of future home healthpatient charts for compliance with the plan of care content for all nursinginterventions. Ongoing 25 patient charts or 25% of daily census(whichever is greater) will be audited weekly. The threshold is 100%. When thethreshold has been met for 4 consecutive weeks, will reduce audits to 10records or 10% of daily census (whichever is greater) monthly. When thethreshold has been met for 2 consecutive months, will be reduced to 10 recordsor 10% of daily census (whichever is greater) quarterly. **Responsible Person:**Director of Quality Assurance	

	included a POC for the initial certification period of 8/02/24 9/30/24. The POC included orders for SN visits three times per week. The record evidenced the SN conducted only a focused assessment of Patient s wounds and/or midline IV on 8/16/25, 8/23/25, 8/28/25, 9/02/25, and 9/11/25. The POC failed to evidence a complete nursing head-to-toe assessment was to be completed only once per week. During an interview on 6/03/25 beginning at 1:38 PM, RN 1 reported she would conduct a head-to-toe physical assessment during the first visit of the week and a focused assessment on Patient s wounds and/or IV during the other two visits. The nurse stated this was not indicated on the POC as the doctor had not sent an order indicating when to conduct a nurse assessment. During an interview on 6/04/25 beginning at 2:50 PM, CM reported the frequency of a full head-to-toe assessment depended on the physician order. The CM was unsure if the POC reflected a SN head-to-toe			

	completed once per week, and a focused assessment only was to be completed for the other two visits. 410 IAC 17-13-1(a)(1)(ix, xiii)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the home health agency failed to ensure the physician was notified for a change in wound bed tissue and/or measurements for 2 of 2 records reviewed with worsening of wound bed tissue or measurements (Patient #1, 3). Findings include: 1. The policy Physician and Care Team Review of Plan of Care, dated 11/2021, indicated Verbal communication will be given to the physician and documented accordingly in the patient s record indicating the condition of the patient, the plan of care,	G0590	1. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** **Action:** Training and education will beprovided to staff on the importance of notifying the physician of changes inthe patient's condition. **Responsible person:** Clinical Educator **Completeddate: by 7/9/25** **2 How are you going to prevent the deficiency from recurring in the future?** **Action:** Audit 100% of future home healthpatient charts for compliance with physician notification. Ongoing 25patient charts or 25% of daily census (whichever is greater) will be auditedweekly. The threshold is	2025-07-09

	and that the physician was notified as frequently as the patient s conditions warrant. 2. Patient #1 s clinical record included a POC for the initial certification period of 8/02/2024 9/30/2024, which indicated Patient was to receive SN visits three times a week for wound care to Patient s wounds to the chest and Left Ventricular Assist Device (LVAD, a pump surgically implanted into the heart to assist with pumping blood for patients with advanced heart failure) driveline site. A SN visit dated 8/05/2024 evidenced the first documented assessment of Patient s wounds. RN 1 noted slough (dead tissue which can impede wound healing) to 50% of Patient s chest wound bed. The record failed to evidence the nurse notified Person A, Patient s physician, of the slough. A SN visit dated 8/09/2024 evidenced RN 1 noted slough to 20% of Patient s chest wound, which was a change from the 8/07/2024 assessment. The record failed to evidence the nurse notified Person A of the		been met for 4consecutive weeks, will reduce audits to 10 records or 10% of daily census(whichever is greater) monthly. When the threshold has been met for 2consecutive months, will be reduced to 10 records or 10% of daily census(whichever is greater) quarterly. **Responsible Person:** Director ofQuality Assurance	

slough.

A SN visit dated 8/12/2024 evidenced RN 1 noted slough to 20% of Patient s LVAD driveline wound and measured the wound at 2.8 centimeters (cm) in length by 4.8 cm in width by 1.5 cm in depth (2.8 cm x 4.8 cm x 1.5 cm), which was an increase by 1.4 cm in width from the 8/09/24 assessment. The record failed to evidence the nurse notified Person A of the new slough or increase in wound width.

During an interview on 6/03/2025 beginning at 1:38 PM, RN 1 stated she would report any changes to a wound, including new presence of slough and/or increase in wound measurement of 0.5 1 centimeter or more, to the physician. When asked if the nurse reported any wound changes to Person A, RN 1 thought one of the wounds had deepened at one point, and she sent a photograph of the wound once a week to Person A.

During an interview on 6/04/2025 beginning at 2:50 PM, CM stated any change to a

	wound should be reported to the physician, including new presence of slough and/or an increase in wound measurement. During an interview on 6/09/2025 beginning at 2:07 PM, Person B, an employee in Person A s office, reported the first wound photographs received was on 8/23/2024. The physician office did not have record of receiving notification of the slough in wounds or change in wound measurement until 9/26/2024.			

	3. Patient #3 s clinical record included a POC for the initial certification period of 2/16/2024 4/15/2024 with a primary diagnosis of osteomyelitis (infection to the bone) in the ankle and foot. SN visits were to be done once a week for five weeks. Patient was admitted to the agency on 2/16/2024 with a non-removable dressing to the right foot. A photograph of Patient s right foot, dated 2/17/2024, evidenced a diabetic ulcer wound to the right lateral (outside) foot below the fifth toe with scabbing over the wound. A SN visit, dated 3/13/2024, evidenced the dressing covering Patient s diabetic ulcer wound had been removed. RN 4 failed to document an assessment of the wound bed tissue. A photograph of the wound, dated 3/13/2024, evidenced black eschar (dead tissue which can impede wound healing) to the wound bed. The record failed to evidence the nurse notified Person G, the physician managing Patient s wounds, of the presence of eschar. A SN visit, dated 3/14/2024,			

	evidenced RN 4 noted Patient s diabetic ulcer wound bed was dusky. A SN discharge visit, dated 3/22/2024, failed to evidence an assessment of Patient s diabetic ulcer wound. The visit note indicated Patient had a follow-up visit with their physician on 4/12/2024. The review of Person G s office visit notes evidenced Patient went to the office on 3/29/2024 due to the diabetic ulcer wound worsening. Patient s diabetic ulcer was debrided (procedure where dead or damaged tissue is removed) during the visit. During an interview on 6/06/2025 beginning at 1:35 PM, RN 4 stated a change in wound bed tissue to eschar would be reported to the physician. The nurse was unsure if Patient had any changes in his/her wound while on services. During an interview on 6/06/2025 beginning at 1:22 PM, Person H, an employee of Person G s office, reported the office had no record it was notified by the home health			

	diabetic ulcer wound. During an interview on 6/06/2025 beginning at 2:25 PM, CM agreed the 3/13/2024 picture of the diabetic ulcer appeared to have eschar in the wound bed, which was a change from the previous photograph. CM stated this change should be reported to the physician. 410 IAC 17-13-1(a)(2)			
G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; Based on record review and interview, the skilled nurse failed to conduct a complete and thorough assessment of the patient for 3 of 7 records reviewed (Patient #1, 3, 7). Findings include: 1. An agency policy Skin and Wound Care, revised 11/2021, indicated wounds should be assessed at a minimum of every seven days by a nurse and measurement documented in the EMR.	G0706	1. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** **Action:** Training and education will beprovided to staff on the importance of complete and thorough assessmentdocumentation. **Responsible person:** Clinical Educator **Completed date:by 7/9/25** **2 How are you going to prevent the deficiency from recurring in the future?** **Action:** Audit 100% of future home healthpatient charts for	2025-07-09

	2. Patient #1 s clinical record evidenced a SOC date of 8/02/24. Patient was discharged on 8/01/24 by Entity C, a hospital. Discharge instructions from Entity C included to notify Patient s physician if there was a greater than 2 change in Patient s Left Ventricular Assist Device (LVAD, a pump surgically implanted into the heart to assist with pumping blood) parameter readings, including flow, power, and pulsatility index (PI, measures the native contractility of the heart). The discharge instructions also indicated Patient s goal Mean Arterial Pressure (MAP, measurement of the average arterial pressure throughout one cardiac cycle, used to monitor LVAD patients as traditional blood pressure methods may not be accurate) was 65 90 millimeters mercury (mmHg). A POC for the initial certification period of 8/02/2024 9/30/2024 and recertification period of 10/01/2024 11/29/2024 included orders for the home health agency to call Person A, Patient s physician, for & swelling of extremities & weight gain of 2-4 pounds over 1-3		through documentation of assessments. Ongoing 25 patient charts or 25% of daily census (whichever isgreater) will be audited weekly. The threshold is 100%. When the threshold hasbeen met for 4 consecutive weeks, will reduce audits to 10 records or 10% ofdaily census (whichever is greater) monthly. When the threshold has been metfor 2 consecutive months, will be reduced to 10 records or 10% of daily census(whichever is greater) quarterly. **Responsible Person:** Director ofQuality Assurance	

	days & SN visits to be done three times a week until 9/23/24, when a new order was obtained for SN visits once per week. A SN visit note, dated 08/05/2024, indicated RN 1 documented a BP of 120/62. The record failed to evidence an assessment of Patient s LVAD parameters and for the presence or absence of edema and weight gain. A SN visit note, dated 08/07/2024, indicated RN 1 documented a BP of 95/61. The record failed to evidence an assessment of Patient s LVAD parameters and for the presence or absence of edema and weight gain. A SN visit note, dated 8/09/2024, indicated RN 1 documented a BP of 99/64. The record failed to evidence an assessment of Patient s LVAD parameters and for the presence or absence of edema and weight gain. A SN visit note, dated 8/12/2024, indicated RN 1 documented a BP of 96/66. The record failed to evidence an assessment of Patient s LVAD			

	parameters and for the presence or absence of edema and weight gain A SN visit note, dated 8/14/2024, indicated RN 1 documented a BP of 98/66. The record failed to evidence an assessment of Patient s LVAD parameters and for the presence or absence of edema and weight gain. SN visit notes, dated 8/16/2024, 8/19/2024, 8/21/2024, 8/23/2024, 8/26/2024, 8/28/2024, 8/30/2024, 9/02/2024, 9/04/2024, 9/06/2024, 9/09/2024, 9/11/2024, 9/13/2024, 9/16/2024, 9/18/2024, 9/23/2024, and 10/08/2024 failed to evidence an assessment of Patient s LVAD parameters and for the presence or absence of edema and weight gain. A SN recertification visit note, dated 9/30/2024, failed to evidence an assessment of Patient s LVAD parameters and for the presence or absence of edema and weight gain. A SN discharge visit note, dated 10/15/2024, failed to evidence an assessment of Patient s			

	LVAD parameters and for the presence or absence of edema and weight gain. During an interview on 6/03/2025 beginning at 1:38 PM, RN 1 reported she would use an automatic BP cuff to obtain a BP on Patient. The nurse stated she would sometimes need to repeat the BP a few times due to an error in the reading. RN 1 reported she would not assess Patient s LVAD parameters, including power, flow, or PI, as it was not within the physician orders. RN 1 reported Patient had issues with peripheral swelling, but she would only document if the swelling was present. RN 1 stated she did not attempt to obtain Patient s weight. During an interview on 6/04/2025 beginning at 2:50 PM, CM reported the nurse should assess Patient s LVAD parameters, including the LVAD flow, power, and PI. CM stated a blood pressure should not be obtained on an LVAD patient as it would not be accurate. CM stated the nurse should document the presence or absence of edema, but agency staff were able to chart by			

	exception. CM reported Patient s weight was only noted on admission. 3. Patient #3 s clinical record included a POC for the initial certification period of 2/16/2024 4/15/2024 with a primary diagnosis of osteomyelitis (infection to the bone) in the ankle and foot. SN visits were to be done once a week for five weeks. Patient was admitted to the agency on 2/16/2024 with a non-removable dressing to the right foot. A photograph of Patient s right foot, dated 2/17/2024, evidenced a diabetic ulcer wound to the right lateral (outside) foot below the fifth toe with scabbing over the wound bed. A SN visit, dated 3/13/2024, evidenced the dressing covering Patient s diabetic ulcer wound had been removed. RN 4 failed to document an assessment of the wound bed tissue nor measurement of the wound. A photograph of the wound, dated 3/13/2024, evidenced black eschar (dead tissue which can impede wound healing) to the wound bed.			

A SN visit, dated 3/14/2024, evidenced RN 4 noted Patient s diabetic ulcer wound bed was dusky. The nurse failed to document an assessment of the wound which included measurements.

A SN discharge visit, dated 3/22/2024, failed to evidence an assessment of Patient s diabetic ulcer wound. The visit note indicated Patient had a follow-up visit with their physician on 4/12/2024.

The review of office visit notes from Person G, a physician managing Patient s wounds, evidenced Patient went to the office on 3/29/2024 due to the diabetic ulcer wound worsening. The wound was debrided (dead tissue removed) during the visit.

During an interview on 6/06/2025 beginning at 1:35 PM, RN 4 reported a wound assessment included measurement and wound bed tissue/appearance. The nurse was unsure if she measured Patient s diabetic ulcer wound after the dressing was removed.

During an interview on 6/06/2025 beginning at 2:25 PM, CM reported there was no

	record of measurements for Patient s diabetic ulcer wound after the dressing was removed. 4. Patient #7 s clinical record included a POC for the initial certification period of 3/23/2022 5/21/2022. The POC indicated Patient was to receive two SN visits per week, with SN interventions to include Assess current pain management regimen including: effectiveness, relief measures, and side effects at each visit & Assess pain including: pain level, frequency, location, quality, precipitating factors, and side effects at each visit &. The record evidenced Patient was hospitalized 3/24/2022 3/31/2022. Former Employee N, an RN, conducted a resumption of care visit on 4/01/2022. The nurse failed to document an assessment of Patient s pain and pain management regimen. During an interview on 6/09/2025 beginning at 3:45 PM, CM reported a pain assessment should be completed at every SN visit.			
N0000	Initial Comments	N0000		

	This visit was for a State Re-Licensure survey of a Home Health Provider. Survey Dates: June 2, 3, 4, 5, 6, 9, 2025 12-Month Unduplicated Skilled Admissions: 0 Abbreviations: CM - Clinical Manager			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of an employee's national/expanded criminal history background check pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.	N0458	**1 How are you going to correct the deficiency? If already corrected,include the following steps and state date of correction.** **Action:** A national background check wascompleted for the Clinical Manager (CM) and placed in the personnel file. **ResponsiblePerson:** Human Resources Director **Completed Date:** 6/24/25 **Action:** A retrospective job specificorientation checklist was completed with CM on 6/24/25. **Responsible Person:**Clinical Educator/Director of Quality **Completed Date:** 6/26/25 **2 How are you going to prevent the deficiency from recurring in the future?** **Action:** Clinical orientation	2025-07-09

	Based on employee file review, policy review, and interview, the home health agency failed to evidence a nationwide background check was completed and orientation to the role was documented for 1 of 1 clinical manager employee file reviewed (CM). Findings include: 1. The agency s HR handbook indicated a State and/or National Criminal History Check will be done within three days of initial employment on all employees. 2. CM s employee file indicated a start date for the role of CM of 3/22/2023. The file failed to evidence a nationwide background check was completed and failed to evidence orientation to the role of CM. 3. During an interview on 6/09/2025 beginning at 2:54 PM, HR Director 6 reported a limited criminal background check for CM was conducted on		checklists foreach new employee and/or role changes will be completed within the first 90days of employment. **Responsible Person:** Clinical Educator/HumanResources Director **Action:** 100% of employee files will be auditedto ensure that background checks and job specific orientation checklists are completedfor each current employee. Ongoing, quarterly audits of 10% of employee fileswill be completed for QAPI to audit existing and new hire employee files, andresults will be reviewed with QAPI committee members quarterly. **ResponsiblePerson:** Human Resources Director/Clinical Educator **Completed date:** by7/9/25	

	becoming CM. The HR Director was unsure if a national criminal background check had been obtained. 4. During an interview on 6/09/2025 beginning at 5:17 PM, CM reported her training for the role consisted of working with the previous administrator and clinical leadership. CM was unsure if there was documentation of her orientation to the role as CM.			
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with:	N0464	**1 How are you going to correct the deficiency? If already corrected,include the following steps and state date of correction.** **Action:** Agency policy “Infection Control –TB Screening of Staff” was updated on 6/11/25 to explicitly adopt the CDC’snational standard for TB testing of employees. **Responsible person:**Infection Control Nurse **Completed date:** 6/11/25 **Action:** An Audit of 100% of patient facing orpotentially patient facing employee files will be conducted for initialemployment TB testing. All	2025-07-09

(A) a documented:

(i) history of tuberculosis;

(ii) previously positive test result for tuberculosis; or

(iii)completion of treatment for tuberculosis; or

(B) newly positive results to the tuberculin skin test;

must have one (1) chest rediograph to exclude a diagnosis of tuberculosis.

(4) After baseline testing, tuberculosis screening must:

(A) be completed annually; and

(B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).

(5) Any person having a positive finding on a tuberculosis evaluation may not:

(A) work in the home health agency; or

(B) provide direct patient contact;

unless approved by a physician to work.

(6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:

(A) working for the home health agency; or

(B) having direct patient contact;

has had a negative finding on a tuberculosis examination within the previous twelve (12) months.

Based on employee file review, policy review, and interview, the home health agency failed to ensure all direct care staff were tested for tuberculosis (TB, an infectious respiratory illness) annually for 4 of 4 employee files

employees who have not been tested atbeginning of employment for TB will undergo a baseline two step Mantoux orQuantiFERON-TB assay. **ResponsiblePerson:** Human Resources Director/Infection Control Nurse **Completed Date:**7/9/25

2 How are you going to prevent the deficiency from recurring in the future?

Action: Orientation Checklists will beupdated for all patient-facing employees to reflect their first patient contactdate to ensure compliance with TB testing. **Responsible Person:** HumanResources/Clinical Educator **Completed date: 6/24/25**

ActionOngoing, 10% of employee files will be audited for QAPI to audit existing andnew hire employee files, and results will be reviewed with QAPI committeemembers quarterly. **Responsible Person:** Human Resources Director/ClinicalEducator **Completed by date:** Beginning quarter 3 QAPI

reviewed of direct care staff hired prior to 2024 (Employee C, D, E, F).

Findings include:

1. The agency policy Infection Control TB Screening of Staff, revised 11/2021, indicated Annual TB testing is mandatory for ALL employees that have the potential for direct patient contact. The policy failed to evidence the agency had adopted a national standard for TB testing of employees.

2. Employee C s employee file evidenced a first patient contact date of 9/08/2021. The file failed to evidence Employee C was tested annually for TB in 2022, 2023, and 2024 using the Mantoux tuberculin skin test (TST, method of testing where a serum is injected under the skin and assessed for reaction) or QuantiFERON-TB assay (blood test for TB).

3. Employee D s employee file evidenced a first patient contact date of 11/09/2023. The record failed to evidence Employee D was tested annually for TB in 2024 using the Mantoux TST or QuantiFERON-TB assay.

4. Employee E s employee file evidenced a first patient contact date of 10/26/2023. The record failed to evidence Employee E was tested annually for TB in 2024 using the Mantoux TST or QuantiFERON-TB assay.

5. Employee F s employee file evidenced a first patient contact date of 4/13/2023. The record failed to evidence Employee E was tested annually for TB in 2024 using the Mantoux TST or QuantiFERON-TB assay.

6. During an interview on 6/09/2025 beginning at 6:22 PM, CM reported the agency had adopted the CDC s national standard for TB screening of employees. CM and RN 5 reported the agency screened its employees annually for TB by having staff complete a questionnaire for the presence or absence of TB symptoms.

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
Danielle Hajicek	Director of Quality Assurance	7/7/2025 9:22:55 AM