	-	ID HUMAN SERVICES			FORI	MAPPROVED
	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMF	PLETED
		15K081	B. WING			C / 22/2019
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 07	22/2013
NEW HOR	ZIZONS HOME HEALTHC	ARE		703 W CHAPEL PIKE		
	1			MARION, IN 46952		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS		G 00	00		
		ederal Recertification and ey in conjunction with an 4) complaints.				
	Survey Dates: 7/15, 7/22/19	7/16, 7/17, 7/18, 7/19 and				
	Facility Number: IN0 Provider Number: 15 Medicaid Number: 20	5K081				
	Complaint # IN00232569: Unsubstantiated, Lack of sufficient evidence Complaint # IN00268066: Unsubstantiated, Lack of sufficient evidence Complaint # IN00223167: Unsubstantiated, Lack of sufficient evidence Complaint # IN00235910: Substantiated, No Federal or State deficiencies were cited.					
	Census Service Type Skilled: 62 Home Health Aide Or Personal Care Only: Total: 121	nly: 41				
	Sample: RR w/HV: 3 RR w/o HV: 5 Total: 8					
	This deficiency reflec accordance with 410	ts State Findings cited in IAC 17.				
G 682	Quality Review comp Infection Prevention	leted: 08/05/19	G 68	32		
LABORATORY	, DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

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 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.

		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 08/07/2019 FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) F		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K081	B. WING				C 07/22/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					703 W CHAPEL PIKE		
NEW HOR	IZONS HOME HEALTHC	ARE			MARION, IN 46952		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 682	82 Continued From page 1		G	682	2		
	CFR(s): 484.70(a)						
	practice, including the precautions, to preve infections and commu- This STANDARD is r Based on observatio interview, the agency followed infection corr for 1 of 3 home visit of Findings include: The agency's undated Hand Hygiene," # D-3 effort to reduce the ris staff members, thorou antisepsis is required Instructions 3. India and hand antisepsis . or intense contact wit client); d. between tas	accepted standards of e use of standard in the transmission of unicable diseases. not met as evidenced by: n, record review and failed to ensure staff atrol policies and procedures observations (patient # 3). d policy titled "Handwashing/ 330, stated "Policy In an sk for infection in clients and ugh hand washing/ hand of all employees Special cations for hand washing c. when there is prolonged h the client (bathing the sks on the same client f.					
	that are potentially co	; g. after touching objects intaminated I. before					
	q. decontaminate har inanimate objects inc immediate vicinity of	luding equipment in the the client [and]					
	Hand Hygiene Techni hands with soap and an amount of product	after removing gloves ique 2. When washing water, wet hands first, apply recommended by the					
	least 20 seconds cov and fingers a. rinse	Is and rub together for at ering all surfaces of hand hands with water and dry					
		oosable towel 3. Multiple not recommended for use in					

Facility ID: 012691

If continuation sheet Page 2 of 6

STATE MENT OF DEFICIENCIES AND PLAN OF CORRECTION (*) PROVIDERSUPPLIENCE A DETIFICATION NUMBER: (*2) MULTIPLE CONSTRUCTION A BUILDING (*3) DATE SUPPLY A BUILDING NAME OF PROVIDER OR SUPPLIER 15K081 ** WING		-	ID HUMAN SERVICES MEDICAID SERVICES			FO	RM APPROVED NO. 0938-0391		
Image: constraint of the product of the pro	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					(X3) DA	(X3) DATE SURVEY COMPLETED		
NEW HORIZONS HOME HEALTHCARE To an interview on 7/17/19 at 2:35 PM, the director of nursing state they had Tjust finished going over handwashing technique during an inservice." To an interview on 7/18/19 at 3:25 PM, the director of nursing state they had Tjust finished going over handwashing technique during an inservice." To an interview on 7/18/19 at 3:25 PM, the director of nursing state they had Tjust finished going over handwashing technique during an inservice." To an interview on 7/18/19 at 3:25 PM, the director of nursing state they had Tjust finished going over handwashing technique during an inservice." To an interview on 7/18/19 at 3:25 PM, the director of nursing state they had Tjust finished going over handwashing technique during an inservice." To an interview on 7/18/19 at 3:25 PM, the director of nursing state they had Tjust finished going over handwashing technique during an inservice." To an interview on 7/18/19 at 3:25 PM, the director of nursing state they had Tjust finished going over handwashing technique during an inservice." To an interview on 7/18/19 at 3:25 PM, the director of nursing state they had Tjust finished going over handwashing technique during an inservice." To an interview on 7/18/19 at 3:25 PM, the director of nursing state they had Tjust finished going over handwashing technique during an inservice." To an interview on 7/18/19 at 3:25 PM, the director of nursing state they had Tjust finished going over handwashing technique during an inservice." To an interview on 7/18/19 at 3:25 PM, the director of nursing state they had Tjust finished going over handwashing technique during an inservice." To an interview on 7/18/19 at 3:25 PM, the director of nursing state they had Tjust finished going over handwashing technique during an inservice." <	15K081			B. WING			-		
NEW HORIZONS HOME HEALTHCARE MARION, IN 46952 (P4) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EQCH DEFICIENCY WOST REPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PREFX (EQCH ORIGINAL AUD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) (20) (20) (EQCH ORIGINAL AUD DE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) (20) (20) (20) (20) (20) (20) (20) (20)	NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP C	ODE			
Prégrix TAG (EACH CORRECTIVE ACTION NUST BE PRECEDED BY FULL REGULATORY OR LS. DENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DEFICIENCY G 682 Continued From page 2 health care settings" G 682 G 682 During a home visit observation with patient # 3, the home health aide (employee E) was observed washing hands less than 20 seconds on 4 occasions, failed to wash hands after pulling lip gloss out of scrub pocket while preparing a meal for the patient; failed to don gloves prior to taking the trash outside to the trash can; and failed to use paper towels to dry hands after pulling lip gloss, out of scrub pocket while preparing a meal for the patient's difty wel towel used to dry patient after the aide showered patient. G 710 In an interview on 7/17/19 at 2:38 PM, employee E stated the agency's handwashing policy is "20 seconds, up and down your arm." G 710 G 710 Provide services in the plan of care CFR(s): 484.75(b)(3) G 710 Providing services that are ordered by the physician as indicated in the plan of care; This ELEMENT is not met as evidenced by: Based on clinical record review and interview,	NEW HOR	IZONS HOME HEALTHC	ARE						
health care settings" During a home visit observation with patient # 3, the home health aide (employee E) was observed washing hands less than 20 seconds on 4 occasions; failed to wash hands after pulling lip gloss out of scrub pocket while preparing a meal for the patient; failed to don gloves prior to taking the trash outside to the trash can; and failed to use paper towels to dry hands after washing, and instead used patient's dirty wet towel used to dry patient after the aide showered patient. In an interview on 7/17/19 at 2:38 PM, employee E stated the agency's handwashing policy is "20 seconds, up and down your arm." In an interview on 7/18/19 at 3:32 PM, the director of nursing state they had "just finished going over handwashing technique during an inservice." 410 IAC 17-12-1(m) Provide services in the plan of care CFR(s): 484.75(b)(3) G 710 Providing services that are ordered by the physician as indicated in the plan of care; This ELEMENT is not met as evidenced by: Based on clinical record review and interview, G 710	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION					
the skilled nurse failed to notify the physician of elevated blood sugars as ordered per the plan of care for 1 of 5 clinical records reviewed for patients with a diagnosis of diabetes type 2 in a universe of 8 clinical records reviewed. (#1) Findings include:		health care settings During a home visit of the home health aide washing hands less th occasions; failed to w gloss out of scrub poor for the patient; failed to the trash outside to th use paper towels to d instead used patient's patient after the aide In an interview on 7/1 E stated the agency's seconds, up and dow In an interview on 7/1 of nursing state they th handwashing techniq 410 IAC 17-12-1(m) Provide services in th CFR(s): 484.75(b)(3) Providing services tha physician as indicated This ELEMENT is no Based on clinical rec the skilled nurse failed elevated blood sugars care for 1 of 5 clinical patients with a diagno universe of 8 clinical rec	" bservation with patient # 3, (employee E) was observed han 20 seconds on 4 ash hands after pulling lip cket while preparing a meal to don gloves prior to taking he trash can; and failed to ry hands after washing, and a dirty wet towel used to dry showered patient. 7/19 at 2:38 PM, employee handwashing policy is "20 n your arm." 8/19 at 3:25 PM, the director had "just finished going over ue during an inservice." e plan of care at are ordered by the d in the plan of care; t met as evidenced by: ord review and interview, d to notify the physician of s as ordered per the plan of I records reviewed for basis of diabetes type 2 in a						

Event ID: K1BR11

Facility ID: 012691

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		D HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K081	B. WING			C 07/22/2019	
NAME OF P	ROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE		
NEW HOR	RIZONS HOME HEALTHC	ARE			703 W CHAPEL PIKE MARION, IN 46952		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ЗE	(X5) COMPLETION DATE
G 710	The agency's undated # C-580, stated "Purp for agency staff to devi individualized to meet Special Instructions completed in full to in- treatments, and proce The agency's undated Orders," # C 635 Add medications, treatmen clients must be ordered Procedure visits sh adequate reasons an- a missed visit which shall be documented physician the patien representative must a documented on the cl communication note a missing the visit. (It is rights to alter the plan notification.)" The clinical record for 7/15/19. The start of diagnoses of diabete procedure; chronic ob and blind right eye. T reviewed was 6/12/19 (POC) listed a Humal stated for glucose lev and call the physician On 6/23/19, 6/26/19 a nurses documented g and 356. Each time t administering 10 units	d policy titled "Plan of Care," hose to provide guidelines velop a plan of care is specific identified needs . the plan of care shall be clude medications, edures" d policy titled "Physician endum, stated "Policy All nts and services provided to ed by a physician. ould only be missed for d not for staff convenience h cannot be rescheduled and communicated to the nt and/or patient also be notified this is inical note or also with the rationale for is a violation of the patient's of care without r patient #1 was reviewed on care date was 6/12/19 with s mellitus type 2; surgical petructive pulmonary disease the certification period 0 - 8/10/19. The plan of care og sliding scale order that el of 351 - 400 give 10 units 	G	710			

Facility ID: 012691

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391		
				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
15K081			B. WING			C 07/22/2019			
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•			
NEW HOR	IZONS HOME HEALTHC	ARE		703 W CHAPEL PIKE MARION, IN 46952					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(X5) COMPLETION DATE			
G 710	physician was notified In an interview on 7/1 on nursing stated that contacted there would	as ordered in the POC. 8/19 at 3:25 PM, the director	G	710					
G1014	responses to those in This ELEMENT is no Based on clinical rec failed to ensure they r ensure desired levels clinical records review diagnosis of diabetes clinical records review Findings include: The clinical record for 7/15/19. The start of diagnoses of diabete procedure; chronic ob and blind right eye. T reviewed was 6/12/19 (POC) listed a Humal stated for glucose leve and call the physician On 6/23/19, 6/26/19 a	ent response) dding medication ents, and services, and terventions; t met as evidenced by: ord review, the skilled nurse rechecked glucose levels to were achieved for 1 of 5 ved for patients with a type 2 in a universe of 8 ved. * patient #1 was reviewed on care date was 6/12/19 with s mellitus type 2; surgical estructive pulmonary disease the certification period 0 - 8/10/19. The plan of care og sliding scale order that el of 351 - 400 give 10 units and 6/28/19, two different lucose levels of 380, 398,	G1	014					

Facility ID: 012691

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 08/07/20 FORM APPROVE OMB NO. 0938-039	ED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K081	B. WING		_	C 07/22/2019	
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, ST	ATE, ZIP CODE	•••==	
NEW HOP	ZIZONS HOME HEALTHC	ARE		703 W CHAPEL PIKE MARION, IN 46952			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		N
G1014	administering 10 units sliding scale order, bu	s of Humalog insulin per ut failed to rechecked ure the 10 units of Humalog	G101				

Event ID: K1BR11

Facility ID: 012691

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