STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K083	A. BUILDING B. WING	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURPOSE HOME HEALTH	5455 HARRISON PARK LANE STE B, INDIANAPOLIS, IN, 46216

(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
G0000	INITIAL COMMENTS This visit was for the investigation of a Federal and State complaint/intake of a Medicaid Home Health provider. Survey Dates: 03-06-2023, 03-07-2023, and 03-08-2023 Complaint # 96546 Substantiated; with deficiencies cited. Purpose Home Health was found out of compliance with Condition of Participation 42 CFR 484.50, Patient Rights, in relation to the complaint allegations. An Immediate Jeopardy was identified which began on 02-28-2023. The Immediate Jeopardy was announced on 03-08-2023, at 8:28 AM for 42 CFR 484.50, Patient Rights. The agency failed to perform a complete	G0000	*POC accepted on 3-30-2023* *Deborah Franco, RN*	

	investigation to ensure Patient #1's safety when Patient #1 indicated to their home health aide (HHA) #1 they had been hit by their spouse, who had guardianship over the patient, and indicated the spouse had stolen property items from them. The agency failed to perform a comprehensive assessment, failed to notify the physician, failed to notify Entity H (the assisted living facility where Patient #1 resided) failed to notify Adult Protective Services or law enforcement regarding Patient #1's allegations of abuse, and failed to provide for Patient #1's safety while the allegations were investigated. The failure to perform these actions created a likelihood of the risk of serious harm, impairment, disability, or death, and resulted in Immediate Jeopardy to 251 (patients with a diagnosis of dementia) of the current census of 801 patients. The Administrator was notified of the Immediate Jeopardy (IJ) on 03-08-2023 at 08:28 AM. The agency submitted a 2nd revised removal plan for the immediacy component of the IJ for 42 CFR 484.50, Patient Rights on			

	03-08-2023 at 3:36 PM. The agency's revised removal plan was found to be acceptable. The Immediate Jeopardy was not abated by the end of the exit conference on 03-08-2023 at 03:58 PM, because on-site verification could not occur with a completion date of 3-17-2023 (9 days future.) QR by Area 3 on 3-13-2023			
G0406	Patient rights 484.50 Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. Based on record review and interview, the agency failed to ensure the protection and promotion of a patient's rights (Patient #1) upon having received a report of physical abuse for a patient with a cognitive deficit (diagnosis of dementia) by having failed to conduct/document an investigation that included a physical assessment and an interview with the patient and a	G0406	1. Agency corrected the deficient practice for the client cited in the deficiency by contacting the Fishers police department 3/8/23 and filed a report. Additionally, the agency called APS on 3/8/23 and filed a report. RN CM completed a physical assessment and a vulnerability assessment on the patient 3/8/23. 2. Agency conducted an audit of diagnoses for all patients. Agency determined that all patients with the diagnosis of dementia had the potential to be affected by the deficient practice. Agency implemented a Vulnerability Assessment form. RN CM's completed a vulnerability assessment form for all patients with the potential to be affected by the deficient practice. Agency conducted an investigation on any patient who reported that they did not feel safe, that their needs were not being met, or could not verbalize how to obtain assistance for themselves. 3. Agency reviewed the following policies: Identifying and Reporting Abuse/Neglect and Exploitation of Clients, Abuse Prevention Plan, Client/Family Complaint/Grievance Policy. Agency revised the following policies: Identifying and Reporting Abuse/Neglect and	2023-04-01

	witness identified in the abuse report (G478) in relation to their allegation of abuse and misappropriation of property by their spouse. The failure to take action to protect the affected patient (G486) and failure to report allegations of abuse and misappropriation of property to the appropriate authorities (G488) created the likelihood of risk of serious injury, harm, impairment, or death for all of its cognitively impaired patients (251 of 801 patients on census). The cumulative effects of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of 42 CFR 484.50, Patients Rights. The Findings include: 1. A policy received 03-06-2023 at 10:58 AM, from the Agency's Administrator, "3-540 IDENTIFYING AND REPORTING ABUSE/NEGLECT/EXPLOITATIO N OF CLIENTS," approved by the Governing Body on 11-03-2022, indicated but was not limited to, "Clients have the right to be free from mental		Exploitation of Clients and Client/Family Complaint/Grievance Policy. Agency implemented the process to complete Vulnerability Assessment for all patients upon admission. Any patient determined at risk based on the initial Vulnerability Assessment will have the Vulnerability Assessment completed at a minimum every 60 days. Agency will investigate any report of suspected abuse/neglect/misappropriation of property. RN's will conduct a physical assessment of a patient within 24 hours for all reports of suspected abuse/neglect. All suspected reports of abuse/neglect will be reported to the police, patients physician, ALF and Supported Living, and APS within 24 hours. Misappropriation of property will be reported to the police within 24 hours. All company employees with patient contact will be in-serviced on the definition of a vulnerable patient, the definition of abuse, and how to report abuse and who to report it to. All Clinical Administrative staff and RN's were educated on the following policies: Identifying and Reporting Abuse/Neglect and Exploitation of Clients and Client/Family. Complaint/Grievance Policy. All Clinical Administrative staff and RN's were educated on the completion of the Vulnerability Assessment form. 4. All agency policies will be reviewed annually. All agency staff with patient contact will be in-serviced on Identifying and Reporting Abuse/Neglect and Exploitation of Clients and Client/Family Complaint/Grievance policy upon hire date and then annually. Agency will regulatory guidelines for dementia training for all home health aide staff. Agency will audit clinical record of 100% of admissions at a minimum of weekly basis to ensure that a Vulnerability Assessment was completed for all patients. Documentation of audit and findings will be monitored monthly in the Quality Assessment Improvement Program until there are six consecutive months of negative findings. Agency will audit clinical record of 100% of patients determined to be at risk to ensure that a Vulnerability Assessment was completed at a minimum of every 60 days on a weekly basis to ensure that a Vulnerability	

	physical sexual and verbal abuse, neglect, and exploitation ... Employee/Agency Responsibilities ... The Director of Clinical Supervision/designee will review the information presented and investigate if this is a reportable incident. If so, the information will be reported to the appropriate county social service Agency or Adult/Child Protection agency by the Administrator or an appropriate designee ... " 2. A policy received on 03-06-2023 at 10:58 AM, from the Agency's Administrator, "3-560 ABUSE PREVENTION PLAN," indicated but was not limited to, "All clients admitted to the agency will be assessed for vulnerability. An individual abuse prevention plan for individuals suspected or determined to be vulnerable will be documented in the Care Plan ... Client Assessment: The following situations need to be addressed: Physically frail or severe functional limitations ... decreased mental functioning ... Client/family behaviors that may pose safety risks ... the comprehensive assessments and modifications to the plan of care will be documented in the		patients. Documentation of audit and findings will be monitored monthly in the Quality Assessment Improvement Program until there are six consecutive months of negative findings. Corrective actions and results of Quality Assessment Program findings will be monitored by agency Administrator.	

clinical record. Effectiveness of the plan will also be documented and if client safety is not achieved appropriate disciplines will be notified and care conference set up to address possible alternatives ... "

3. A review of a document "Grievances 2023," received from the Alternate Administrator on 03-06-2023 at 11:55 AM, evidenced on 2/28/2023, Patient #1 had reported to home health aide #1 (HHA) their spouse hit them 2 times and takes things. The description of the resolution of the grievance evidenced Entity B, an agency that is responsible for the management of care for disabled adults was updated and Entity H (assisted living facility of Patient #1) was notified. The document evidenced a State reportable had been entered.

4. A review of the clinical record for Patient #1, start of care date of 12-13-2022, indicated, but was not limited to, diagnoses of Hemiplegia

	one side of the body) following cerebral infarction (stroke), unspecified dementia with behavioral disturbances, major depressive disorder, anxiety..." The record evidenced Patient #1 resided in an assisted living facility (ALF). The clinical record failed to evidence a vulnerability assessment was completed for Patient #1 at admission, recertification, or at the time of the reported physical abuse allegation. The clinical record failed to evidence documentation of any home health agency case conferences. 5. A review of Case communication notes evidenced: On 2-28-23, an untimed entry by RN #5/ Clinical Manager for Patient #1, indicated HHA #1 called to report Patient #1 had made allegations that their spouse was abusive to them, and Patient #1 had a witness. Patient #1 reported to the HHA that their spouse had hit them and would take their items and money. Patient #1 indicated recently having a cellphone but			

now the phone was gone because Patient #1's spouse took it.

On 2-28-23, an untimed entry indicated RN #5/ Clinical Manager for Patient #1 spoke with RN #2, and updated Patient #1's allegations. RN #2 was scheduled for a supervisory visit (a visit to supervise the HHA for Patient #1) today if RN #2 has any concerns (Employee #2) would contact the office.

On 2-28-23, an untimed entry indicated the Director of Nursing (DON) documented "If (sic witness) can state ... saw (sic Patient # 1) being hit by [sic] spouse or (Patient #1) says ... has been hit by ... spouse we must complete a State Reportable and complete an investigation."

On 2-28-23, an untimed entry indicated the DON called and spoke with HHA #1 again and confirmed Patient #1 told HHA #1 they had been hit by their

moved into the ALF (Entity H) and once while living in their current ALF apartment (Entity H.)

On 2-28-23 an untimed entry indicated RN #5/ Clinical Manager for Patient #1 updated the communication notes that this was a state reportable.

6. A review of a 03-01-23, untimed case communication note indicated the agency called the ALF's DON, Person A, and left a voicemail that the home health agency was completing a state reportable because of Patient #1's allegation their spouse was abusive, to include having hit them. The note indicated the DON of the ALF, Person A, did not believe the spouse had hit Patient #1.

7. A review of Patient #1's care visits evidenced RN #2 had made a visit on 02-28-2023 that was time-stamped with a beginning time of 2:44 PM and

documented a supervisory visit of the home health aide was completed. No other documentation was recorded to evidence an assessment for the presence or absence of injuries/injuries of unknown origin or a specific abuse-focused interview with Patient #1 regarding their allegation of physical abuse and their safety concerns.

8. Interviews:

On 03-06-23 at 11:37 AM, HHA#1 confirmed having received an allegation from Patient #1 that their spouse had physically abused them and taken pr#operty without permission (to include their cell phone.) HHA #1 reported they saw the patient with the cell phone one day and it was gone the next day. HHA #1 indicated Patient #1 told them their spouse had stolen it. HHA #1 reported Patient #1 had expressed they were scared. HHA #1 indicated he had observed Patient #1 hiding personal items and keeping the apartment door locked,

	blocking it with their wheelchair, and allowing entry only after seeing who was at the door. On 03-07-23 at 8:44 AM, during an interview with the Agency's Administrator, she reported that Clinical Manager, RN #5, did an interview over the phone with Patient #1 after the allegation was received. The administrator further reported a RN #2 went to visit Patient #1 the day after the allegation was reported. The administrator was unable to show documentation that a physical, risk, or psychosocial assessment was completed and reported, "we typically don't." The administrator indicated RN #2 reported the physical abuse had happened on previous dates. When asked what had been put in place for Patient #1's protection she reported, "we are not there with [sic Patient #1] so we notified everyone we could." The administrator indicated the ALF (entity H) did not believe Patient #1's allegations. The administrator indicated having submitted reports to the state, the ALF, and Entity B (an agency responsible to manage elderly			

	and disabled patients' care.) She confirmed the agency had not reported Patient #1's allegations to Adult Protect Services, the Police, or Patient #1's physician. The administrator stated, "If we felt [sic Patient #1] was in immediate danger we would have called APS." During an interview on 03-07-23 at 11:32 AM, Patient #1 reported last Friday (03-03-23) their spouse tried to get into the apartment, and Patient #1 had held the door closed with their foot and right hand. Patient #1 reported they did not want the spouse in their apartment. When queried if they were fearful of the spouse, Patient #1 answered, " I am fearful of (spouse) physically, just don't want (spouse) to visit." During an interview on 03-07-23 at 12:33 PM, with the Director of Nursing of Entity H (ALF), Person A, where Patient #1 resided, reported the ALF (Entity H) they had done an			

	and had contacted APS and had provided resources to Patient #1. The Director of Entity H, Person A, was unable to confirm that Purpose Home Health agency was aware of the ALF's actions.			
G0478	Investigate complaints made by patient 484.50(e)(1)(i) (i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics: Based on record review and interview, the agency failed to implement their abuse and neglect policies in 1 of 8 records reviewed (Patient #1). The findings include: 1. A policy received 03-06-2023 at 10:58 AM, from the Agency's Administrator, "3-540 IDENTIFYING AND REPORTING ABUSE/NEGLECT/EXPLOITATIO N OF CLIENTS," approved by the Governing Body on 11-03-2022, indicated but was not limited to, "Clients have the right to be free from mental physical sexual and verbal abuse, neglect, and exploitation	G0478	1. Agency corrected the deficient practice for the client cited in the deficiency by contacting the Fishers police department 3/8/23 and filed a report. Additionally, the agency called APS on 3/8/23 and filed a report. RN CM completed a physical assessment and a vulnerability assessment on the patient 3/8/23. 2. Agency conducted an audit of diagnoses for all patients. Agency determined that all patients with the diagnosis of dementia had the potential to be affected by the deficient practice. Agency implemented a Vulnerability Assessment form. RN CM's completed a vulnerability assessment form for all patients with the potential to be affected by the deficient practice. Agency conducted an investigation on any patient who reported that they did not feel safe, that their needs were not being met, or could not verbalize how to obtain assistance for themselves. 3. Agency reviewed the following policies: Identifying and Reporting Abuse/Neglect and Exploitation of Clients, Abuse Prevention Plan, Client/Family Complaint/Grievance Policy. Agency revised the following policies: Identifying and Reporting Abuse/Neglect and Exploitation of Clients and Client/Family Complaint/Grievance Policy. Agency implemented the process to complete Vulnerability Assessment for all patients upon admission. Any patient determined at risk based on the initial Vulnerability Assessment will have the Vulnerability Assessment completed at a minimum every 60 days. Agency will investigate any report of suspected abuse/neglect/misappropriation of	2023-04-01

	… Employee/Agency Responsibilities … The Director of Clinical Supervision/designee will review the information presented and investigate if this is a reportable incident. If so, the information will be reported to the appropriate county social service Agency or Adult/Child Protection agency by the Administrator or an appropriate designee. " A policy received on 03-06-2023 at 10:58 AM, from the Agency's Administrator, "3-560 ABUSE PREVENTION PLAN," indicated but was not limited to, "All clients admitted to the agency will be assessed for vulnerability. An individual abuse prevention plan for individuals suspected or determined to be vulnerable will be documented in the Care Plan … Client Assessment: The following situations need to be addressed: Physically frail or severe functional limitations decreased mental functioning Client/family behaviors that may pose safety risks … the comprehensive assessments and modifications to the plan of care will be documented in the clinical record. Effectiveness of the plan will also be		property. RN's will conduct a physical assessment of a patient within 24 hours for all reports of suspected abuse/neglect. All suspected reports of abuse/neglect will be reported to the police, patients physician, ALF and Supported Living, and APS within 24 hours. Misappropriation of property will be reported to the police within 24 hours. All company employees with patient contact will be in-serviced on the definition of a vulnerable patient, the definition of abuse, and how to report abuse and who to report it to. All Clinical Administrative staff and RN's were educated on the following policies: Identifying and Reporting Abuse/Neglect and Exploitation of Clients and Client/Family. Complaint/Grievance Policy. All Clinical Administrative staff and RN's were educated on the completion of the Vulnerability Assessment form. 4. All agency policies will be reviewed annually. All agency staff with patient contact will be in-serviced on Identifying and Reporting Abuse/Neglect and Exploitation of Clients and Client/Family Complaint/Grievance policy upon hire date and then annually. Agency will regulatory guidelines for dementia training for all home health aide staff. Agency will audit clinical record of 100% of admissions at a minimum of weekly basis to ensure that a Vulnerability Assessment was completed for all patients. Documentation of audit and findings will be monitored monthly in the Quality Assessment Improvement Program until there are six consecutive months of negative findings. Agency will audit clinical record of 100% of patients determined to be at risk to ensure that a Vulnerability Assessment was completed at a minimum of every 60 days on a weekly basis to ensure that a Vulnerability Assessment was completed for all at risk patients. Documentation of audit and findings will be monitored monthly in the Quality Assessment Improvement Program until there are six consecutive months of negative findings. Corrective actions and results of Quality Assessment Program findings will be monitored by agency Administrator.	

	documented and if client safety is not achieved appropriate disciplines will be notified and care conference set up to address possible alternatives ..." 2. A review of the clinical record for Patient #1 admitted on 12-13-2022, indicated but was not limited to diagnoses of Hemiplegia and Hemiparesis (paralysis of one side of the body)following cerebral infarction (stroke), unspecified dementia with behavioral disturbances, major depressive disorder, anxiety ..." The record reported Patient #1 resided in an assisted living facility (ALF). The document failed to evidence a vulnerability assessment completed on admission, recertification, or at the time of the reported allegation. 3. A review of a document "Grievances 2023," received from the Alternate Administrator on 03-06-2023 at 11:55 AM, contained but was not limited to, "2/28/2023 (Name of Patient #1) Person Reporting, Employee #1, HHA (SIC Home Health Aide) ... HHA reported the client stated ... (spouse) hit [them] 2 times and			

takes ... things ... DESCRIPTION OF RESOLUTION (Entity B, agency managing older disabled adults) updated, Entity H, (assisted living facility of Patient #1) notified. State reportable entered."

4. A review of Patient #1's care visit notes completed by an RN #2 evidenced a visit on 02-28-2023 that was time-stamped enter at 2:44 PM, exit at 02:45 PM, and was completed by RN #2. The visit note indicated a supervisory visit of the home health aide was completed. No other documentation evidenced the RN interviewed or conducted a physical assessment of Patient #1 for evidence of injury/harm.

5. A case communication note dated 03-02-2023 by Employee #5, a Clinical Manager, included an interview over the phone with Patient #5 where Patient #5 reported their spouse had hit them and the patient provided specific dates in 2021 and 2022. Patient # 5 continued to report items stolen by their spouse and requested a no-contact order.

	6. On 03-07-23 at 8:44 AM, during an interview with the Agency's Administrator, she reported that a clinical manager in the office did an interview over the phone with Patient #1 after the allegation was received. She further reported a nurse went to visit Patient #1 the day after the allegation was reported. The administrator reviewed the visit note and verified there was no documentation of an abuse-focused interview or of a physical assessment, vulnerability assessment, or psychosocial assessment, and indicated "we typically don't." She reported the physical abuse happened on previous dates. When asked what has been put in place for Patient #1's protection she reported, "we are not there with him, so we notified everyone we could." The administrator indicated the ALF had shared they did not believe Patient #1's allegations. The administrator indicated we reported to the state, ALF, and Entity B. She confirmed the agency had not reported Patient #1's allegations to Adult Protect Services, the Police, or Patient #1's physician. She stated, "If we felt [sic			

	Patient #1] was in immediate danger we would have called APS.			
G0486	Protect patient during investigation 484.50(e)(1)(iii) (iii) Take action to prevent further potential violations, including retaliation, while the complaint is being investigated. Based on record review and interview the agency failed to take action to prevent further potential risk of physical abuse and misappropriation of the patient's property in 1 of 7 (Patient #1) records reviewed. The Findings Include: A policy received on 03-06-2023 at 10:58 AM from the Agency's Administrator titled, "3-560 ABUSE PREVENTION PLAN" indicated but not limited to, "All clients admitted to the agency will be assessed for vulnerability. An individual abuse prevention plan for individuals suspected or determined to be vulnerable will be documented in the Care Plan... Client Assessment: The following situations need to be	G0486	1. Agency corrected the deficient practice for the client cited in the deficiency by contacting the Fishers police department 3/8/23 and filed a report. Additionally, the agency called APS on 3/8/23 and filed a report. RN CM completed a physical assessment and a vulnerability assessment on the patient 3/8/23. 2. Agency conducted an audit of diagnoses for all patients. Agency determined that all patients with the diagnosis of dementia had the potential to be affected by the deficient practice. Agency implemented a Vulnerability Assessment form. RN CM's completed a vulnerability assessment form for all patients with the potential to be affected by the deficient practice. Agency conducted an investigation on any patient who reported that they did not feel safe, that their needs were not being met, or could not verbalize how to obtain assistance for themselves. 3. Agency reviewed the following policies: Identifying and Reporting Abuse/Neglect and Exploitation of Clients, Abuse Prevention Plan, Client/Family Complaint/Grievance Policy. Agency revised the following policies: Identifying and Reporting Abuse/Neglect and Exploitation of Clients and Client/Family Complaint/Grievance Policy. Agency implemented the process to complete Vulnerability Assessment for all patients upon admission. Any patient determined at risk based on the initial Vulnerability Assessment will have the Vulnerability Assessment completed at a minimum every 60 days. Agency will investigate any report of suspected abuse/neglect/misappropriation of property. RN's will conduct a physical assessment of a patient within 24 hours for all reports of suspected abuse/neglect. All suspected reports of abuse/neglect will be reported to the police, patients physician, ALF	2023-04-01

	severe functional limitations decreased mental functioning Client/family behaviors that may pose safety risks...the comprehensive assessments and modifications to the plan of care will be documented in the clinical record. Effectiveness of the plan will also be documented and if client safety is not achieved appropriated disciplines will be notified and care conference set up to address possible alternatives..." A review of the clinical record for Patient #1 admitted on 12-13-2022, indicated but not limited to diagnoses including Hemiplegia and Hemiparesis (paralysis of one side of the body)following cerebral infarction. (stroke), unspecified dementia with behavioral disturbances, major depressive disorder, anxiety...". The record reported Patient #1 resided in an assisted living facility. The document failed to evidence a vulnerability assessment completed on admission, recertification, or time of the reported allegation. A review of a document titled "Grievances 2023" received from the Alternate		and Supported Living, and APS within 24 hours. Misappropriation of property will be reported to the police within 24 hours. All company employees with patient contact will be in-serviced on the definition of a vulnerable patient, the definition of abuse, and how to report abuse and who to report it to. All Clinical Administrative staff and RN's were educated on the following policies: Identifying and Reporting Abuse/Neglect and Exploitation of Clients and Client/Family. Complaint/Grievance Policy. All Clinical Administrative staff and RN's were educated on the completion of the Vulnerability Assessment form. 4. All agency policies will be reviewed annually. All agency staff with patient contact will be in-serviced on Identifying and Reporting Abuse/Neglect and Exploitation of Clients and Client/Family Complaint/Grievance policy upon hire date and then annually. Agency will regulatory guidelines for dementia training for all home health aide staff. Agency will audit clinical record of 100% of admissions at a minimum of weekly basis to ensure that a Vulnerability Assessment was completed for all patients. Documentation of audit and findings will be monitored monthly in the Quality Assessment Improvement Program until there are six consecutive months of negative findings. Agency will audit clinical record of 100% of patients determined to be at risk to ensure that a Vulnerability Assessment was completed at a minimum of every 60 days on a weekly basis to ensure that a Vulnerability Assessment was completed for all at risk patients. Documentation of audit and findings will be monitored monthly in the Quality Assessment Improvement Program until there are six consecutive months of negative findings. Corrective actions and results of Quality Assessment Program findings will be monitored by agency Administrator.	

	Administrator on 03-06-2023 at 11:55 AM, contained but not limited to, "2/28/2023 (Name of Patient #1) Person Reporting, Employee #1, HHA (SIC Home Health Aide) ...HHA reported the client stated ... (spouse) hit him 2 times and takes... things...DESCRIPTION OF RESOLUTION (Entity B, agency managing older disabled adults) updated, Entity H, (assisted living facility of Patient #1)notified. State reportable entered A review of Patient #1's calendar of visits completed by an Agency Nurse evidenced a visit on 02-28-2023 that was time-stamped " 02:44 PM-02:45 PM" completed by RN #2 with notes indicating a supervisory visit of the home health aide was completed. No other entry evidencing an assessment of Patient #1 was completed. A case communication note dated 03-02-2023 by Employee #5, Clinical Manager, included an interview over the phone with Patient #5 where Patient #5 reported his spouse had hit them and provided specific dates in 2021 and 2022. Patient # 5 continued to report items			

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	During an interview on 03-07-23 at 11:32 AM Patient #1 reported that last Friday the spouse tried to get into the apartment and Patient #1 held the door closed with their foot and right hand. Patient #1 reported they did not want the spouse in their apartment. When queried if they were fearful of the spouse, they answered, " I am fearful of her physically, just don't want (spouse) to visit."			
G0488	Immediate reporting of abuse by all staff 484.50(e)(2) Any HHA staff (whether employed directly or under arrangements) in the normal course of providing services to patients, who identifies, notices, or recognizes incidences or circumstances of mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, or misappropriation of patient property, must report these findings immediately to the HHA and other appropriate authorities in accordance with state law.	G0488	1. Agency corrected the deficient practice for the client cited in the deficiency by contacting the Fishers police department 3/8/23 and filed a report. Additionally, the agency called APS on 3/8/23 and filed a report. RN CM completed a physical assessment and a vulnerability assessment on the patient 3/8/23. 2. Agency conducted an audit of diagnoses for all patients. Agency determined that all patients with the diagnosis of dementia had the potential to be affected by the deficient practice. Agency implemented a Vulnerability Assessment form. RN CM's completed a vulnerability assessment form for all patients with the potential to be affected by the deficient practice. Agency conducted an investigation on any patient who reported that they did not feel safe, that their needs were not being met, or could not verbalize how to obtain assistance for themselves. 3. Agency reviewed the following policies: Identifying and Reporting Abuse/Neglect and Exploitation of Clients, Abuse Prevention Plan,	2023-04-01

	Based on record review the agency failed to report allegations of abuse and misappropriation of property to all of the appropriate authorities in 1 of 8 records reviewed. 1. A policy received 03-06-2023 at 10:58 AM, from the Agency's Administrator, titled "3-540 IDENTIFYING AND REPORTING ABUSE/NEGLECT/EXPLOITATIO N OF CLIENTS" approved by the Governing Body 11-03-2022, indicated but not limited to, "Clients have the right to be free from mental physical sexual and verbal abuse, neglect, and exploitation...Employee/Agency Responsibilities...The Director of Clinical Supervision/designee will review the information presented and investigate if this is a reportable incident. If so, the information will be reported to the appropriate county social service Agency or Adult/Child Protection agency by the Administrator or an appropriate designee. " 2. A review of the clinical record for Patient #1 admitted on 12-13-2022, indicated but not limited to diagnoses including Hemiplegia and Hemiparesis (paralysis of one side of the		Client/Family Complaint/Grievance Policy. Agency revised the following policies: Identifying and Reporting Abuse/Neglect and Exploitation of Clients and Client/Family Complaint/Grievance Policy. Agency implemented the process to complete Vulnerability Assessment for all patients upon admission. Any patient determined at risk based on the initial Vulnerability Assessment will have the Vulnerability Assessment completed at a minimum every 60 days. Agency will investigate any report of suspected abuse/neglect/misappropriation of property. RN's will conduct a physical assessment of a patient within 24 hours for all reports of suspected abuse/neglect. All suspected reports of abuse/neglect will be reported to the police, patients physician, ALF and Supported Living, and APS within 24 hours. Misappropriation of property will be reported to the police within 24 hours. All company employees with patient contact will be in-serviced on the definition of a vulnerable patient, the definition of abuse, and how to report abuse and who to report it to. All Clinical Administrative staff and RN's were educated on the following policies: Identifying and Reporting Abuse/Neglect and Exploitation of Clients and Client/Family. Complaint/Grievance Policy. All Clinical Administrative staff and RN's were educated on the completion of the Vulnerability Assessment form. 4. All agency policies will be reviewed annually. All agency staff with patient contact will be in-serviced on Identifying and Reporting Abuse/Neglect and Exploitation of Clients and Client/Family Complaint/Grievance policy upon hire date and then annually. Agency will regulatory guidelines for dementia training for all home health aide staff. Agency will audit clinical record of 100% of admissions at a minimum of weekly basis to ensure that a Vulnerability Assessment was completed for all patients. Documentation of audit and findings will be monitored monthly in the Quality Assessment Improvement Program until there are six consecutive months of negative findings. Agency will audit clinical record of 100% of patients determined to be at risk to ensure that a Vulnerability Assessment was	

	body)following cerebral infarction. (stroke), unspecified dementia with behavioral disturbances, major depressive disorder, anxiety...". The record reported Patient #1 resided in an assisted living facility. The document failed to evidence a vulnerability assessment completed on admission, recertification, or time of the reported allegation. 3. A review of a document titled "Grievances 2023" received from the Alternate Administrator on 03-06-2023 at 11:55 AM, contained but not limited to, "2/28/2023 (Name of Patient #1) Person Reporting, Employee #1, HHA (SIC Home Health Aide) ...HHA reported the client stated ... (spouse) hit him 2 times and takes... things...DESCRIPTION OF RESOLUTION (Entity B, agency managing older disabled adults) updated, Entity H, (assisted living facility of Patient #1)notified. State reportable entered. 4. A review of Patient #1's calendar of visits completed by an Agency Nurse evidenced a visit on 02-28-2023 that was time-stamped " 02:44 PM-02:45		completed at a minimum of every 60 days on a weekly basis to ensure that a Vulnerability Assessment was completed for all at risk patients. Documentation of audit and findings will be monitored monthly in the Quality Assessment Improvement Program until there are six consecutive months of negative findings. Corrective actions and results of Quality Assessment Program findings will be monitored by agency Administrator.	

PM" completed by RN #2 with notes indicating a supervisory visit of the home health aide was completed. No other entry evidencing an assessment of Patient #1 was completed.

5. A case communication note dated 03-02-2023 by Employee #5, Clinical Manager, included an interview over the phone with Patient #5 where Patient #5 reported his spouse had hit them and provided specific dates in 2021 and 2022. Patient # 5 continued to report items stolen by their spouse and requested a no-contact order.

6. On 03-07-23 at 8:44 Am during an interview with the Agency's Administrator, she reported that a clinical manager in the office did an interview over the phone with Patient #1 after the allegation was received. She further reported a nurse went to visit Patient #1 the day after (the allegation was reported). She could not confirm a physical, risk, or psychosocial assessment was completed and reported, "we typically don't". She reported

	previous dates. When asked what has been put in place for Patient #1's protection she reported, "we are not there with him, so we notified everyone we could". The ALF did not believe him. We reported to the state, ALF, and Entity B. She confirmed no report was made to Adult Protect Services, the Police, or Patient #1's physician by this agency. She stated, "If we felt he was in immediate danger we would have called APS (Adult Protect Services). The agency failed to contact APS or the Police.			

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
Angie Wrightsman	DON, Administrator	3/30/2023 1:19:41 PM