| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 15K152 | A. BUILDING<br>B. WING | 06/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| TEAM SELECT HOME CARE | 5614 INDUSTRIAL ROAD, FORT WAYNE, IN, 46825 |

| (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 |
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| G0000 | INITIAL COMMENTS<br><br>This survey was for a Federal and State complaint of a Home Health Agency Provider.<br><br>Survey Dates: May 30, 31, June 01, 02, and 05, 2023<br><br>Complaint: 98819 was investigated; related and unrelated Federal and State deficiencies were cited.<br><br>12-month unduplicated skilled census: 156<br><br>Survey was Fully Extended 06/02/2023.<br><br>During this Federal and State Complaint Survey, Team Select was found to be out of compliance with Conditions of Participation 484.55 Comprehensive Assessment of Patients and the Conditions of Participation 484.60, Care | G0000 | Team Select of FortWayne ("Team Select") submits the following Plan of Correction as required byState and Federal law. Team Select's submission of this Plan ofCorrection should not be taken as an agreement with or admission of any of thefindings contained therein. Team Select hereby expressly reserves the right tochallenge the factual findings, legal conclusions, and allegations contained inthe underlying reports.<br><br>Compliance has beenand will be achieved no later than the last completion date identified in thePlan of Correction. Team Select desires this Plan of Correction submissionto be considered our Creditable Allegation of Compliance. | |

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| | Planning, Coordination of Services, and Quality of Care.<br><br>Based on the Condition-level deficiencies during the 06/05/2023 survey, your home health agency was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 06/02/2023. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning June 5, 2023, and continuing through June 4, 2025.<br><br>This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.<br><br>QR: Area 2 6/13/23 | | | |
| G0430 | Be free from abuse<br><br>484.50(c)(2) | G0430 | RN #1identified in the survey report was terminated on 6/2/23. | 2023-06-30 |

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| | Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property;<br><br>Based on record review and interview, the agency failed to ensure Patients were free of abuse, in 1 of 1 one complaint / incident reviewed of registered nurse (RN), (RN 1), with the potential to affect all patients in which RN provided care.<br><br>Findings include:<br><br>1. CMS defines Abuse, and includes the willful infliction of injury, intimidation, resulting in physical harm and or mental anguish. Abuse may be verbal, mental, physical. Verbal abuse refers to and includes abuse perpetrated through any use of disrespectful and or oral language directed toward and in the presence of the Patient. Mental abuse is a type of abuse that includes, but is not limited to, threats of intimidation (e.g. living in fear in one's own home). Physical abuse refers to abuse perpetrated through any action intended to cause physical harm or pain, trauma or bodily harm. | | The Agencycompleted a review of all open incidents and complaints to ensure that anyemployee identified in a report of alleged abuse, neglect or exploitation caseswas immediately suspended during the investigative process, and all Agencyrecords were found to be 100% compliant with this requirement.<br><br>The DON, Administratorhave participated in an in-service for re-education on the complaint andincident reporting processes, including the requirement to suspend any staffinvolved in suspected or alleged abuse, neglect, or exploitation immediately.Additionally, this re-education has been provided to all Agency internal staffmembers to ensure any employee who is involved in any allegation of abuse,neglect or exploitation is immediately suspended and is not allowed to workuntil and unless they are cleared by the Administrator and DON after a thoroughinvestigative process. | |

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| | 2. Review of agency policy dated 12/30/21 and titled "Incident Reporting B-340" indicated the agency will immediately suspend an employee, pending the agency investigation, who is involved in an incident with alleged, suspected, or actual abuse.<br><br>3. Review of the agency's undated personnel policy titled "Safety," indicated any use or possession of a firearm while on company business can result in an employee being disciplined, up to and including termination.<br><br>4. The agency's incident log included an incident, reported by RN 1 and occurred on 5/23/23 at 9:35 PM; incident involved RN 1, Patient 1, and Patient #1's family members. The incident revealed RN 1 reported that a family member entered the home, RN 1 was holding a firearm, and asked the family member to leave the premises.<br><br>The unsigned investigative narrative, dated 5/24/23, was provided by the clinical director; the narrative relayed RN 1 was informed by the director of nursing, that RN 1 they should | | This education will continue to be provided to allincoming staff members during the orientation process. The DON andAdministrator will review any complaints and incident reports at least weeklyfor 60 days to ensure continued compliance with the requirement to immediatelysuspend employees alleged to be involved in abuse, neglect, or exploitation.After 60 days, the DON and Administrator will continue to follow the requiredinvestigation and suspension process, and the DON or designated RN will includea review of all complaints and incident reports during the Agency's quarterlyQAPI audit to ensure compliance is maintained.<br><br>TheAdministrator and DON are responsible for monitoring these corrective actions toensure the deficiency is corrected and will not recur.<br><br>Completed 6/30/23 | |

not have handled a firearm, of any kind, during the provision of care and in a patient's home. The narrative included a response from RN 1, that at the time of the reported incident, he / she was trying to reassemble the firearm that belonged to the primary caregiver of Patient # 1.

Incident investigation indicated agency notified child protective services, adult protective services, police department, physician office, and case management group.

The investigation revealed the agency failed to follow their policy, Incident Reporting B - 340; 5/23/23 was the reported date of the incident, RN #1 provided skilled nurse services to Patient #1 on 5/24/23; the agency did not suspend RN 1 until 5/25/23 at 3:00 PM.

5. A review of clinical record for Patient #1 evidenced RN 1 provided skilled nursing care services for multiple hours, on 5/24/23.

6. Other Roster 3, was interviewed, by phone, on 5/30/2023 at 4:30PM. They

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| | entered the residence of Patient #1; upon entry, RN 1 was standing to the side of Family Member 2, holding a gun, Glock 9mm, which belonged to Family Member 2. Other Roster 3 indicated Patient #1 and Family Member 3, a minor, were present, and indicated RN #1 threatened Other Roster 3 with the gun, as they told Other Roster 3 to leave the home.<br><br>7. During an interview on 6/01/23 at 2:49 PM, the director of clinical service indicated RN #1 was placed on suspension on 05/25/2023 and the investigation moved to their corporate level human resource.<br><br>8. At 3:35 PM, the administrator indicated the agency will terminate RN #1 due to handling a gun and violating professional boundary line with a patient / caregiver. | | | |

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| G0510 | Comprehensive Assessment of Patients<br><br>484.55<br><br>Condition of participation: Comprehensive assessment of patients.<br><br>Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment.<br><br>Based on record review and interview, the home health agency failed to ensure the skilled nurse completed an assessment with an accurate representation of the patient's current status (See G528), failed to ensure the comprehensive assessment included a medication review to identify potential medication issues requiring physician input (See G536), and failed to ensure a recertification comprehensive assessment was conducted during the last 5 days of every 60 days (See G546). | G0510 | Therecertification assessment for patient #4 was completed on 5/31/23. A 100%audit of the recertification timepoints was completed for all Agency patients,and no additional missed recertification visits were found.<br><br>All RNsresponsible for updating the comprehensive assessment at recertification havebeen re-educated on the requirement to complete the recertification visit ondays 56-60 of the certification period, as well as the requirement to ensurethat the medication review, which must be conducted during the comprehensiveassessment visit, is correctly documented within the EMR to reflect the datethe review and assessment were completed. A review of all Agency patients wascompleted to verify that there were no additional patients with laterecertification assessments, and all records were found to be compliant.<br><br>The Agency'ssupervisory and recertification tracking system has been verified against | 2023-06-30 |

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| | The cumulative effects of these systemic problems resulted in the home health agency being found out of compliance with Conditions of Participation 42 CRF 484.55 Comprehensive Assessment of Patients. | | theEMR to ensure that all due dates for future recertification assessments areaccurate. The DON or RN designee will audit the supervisory and recertificationtracker at least weekly for 60 days to ensure that all recertification visitsare completed within the required timeframe. The DON or RN designee will audit100% of comprehensive assessments and corresponding EMR entries for 60 days toensure proper documentation of the medication review. After 60 days ofcompliance, the DON or RN designee will include a review of comprehensiveassessments, including recertification, and medication reviews during the quarterly10% clinical record audit as part of the Agency's QAPI program to ensureongoing compliance is maintained.<br><br>The DON isresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur. | |

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| G0528 | Health, psychosocial, functional, cognition<br><br>484.55(c)(1)<br><br>The patient's current health, psychosocial, functional, and cognitive status;<br><br>Based on record review and interview, the agency failed to ensure the skilled nurse completed an assessment with an accurate representation of the patient's current status in 1of 2 patients with a comprehensive assessment, following a hospitalization (Patient # 6), with the potential to affect all patients.<br><br>Findings include:<br><br>1. Review of an agency wound policy indicated wound assessments should include the location, size, color, status of the wound edges, and type of new skin growth.<br><br>2. A review of the clinical record for Patient #6, included a comprehensive assessment, dated 4/03/23, completed by registered nurse (RN) 4 with notation that the assessment was for the resumption of care, following a hospitalization on | G0528 | RN #4 has beenre-educated on the comprehensive assessment process, including properdocumentation of normal and abnormal breath sounds and the inability todocument the status of wound edges or the wound bed if a wound is documented asbeing “not observable” due to an occlusive dressing that cannot be removed. Documentationof patient #6’s assessment on April 3, 2023 was clarified with the assessingRN, and the clinical record has been updated to address the conflictingdocumentation. | 2023-06-30 |

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| | recertification assessment. The assessment relayed Patient was admitted to the hospital for a planned surgical intervention on 03/29/23 and was discharged 4/01/23.<br><br>The assessment included documentation that described the healing status of a surgical wound as with new tissue growth and intact wound edges (the edges meet, are flush with surrounding skin) and included documentation that indicated the wound was not observable because it was covered with a dressing, applied the day of surgery, and the dressing was not to be removed until Wednesday, (April 05, 23).<br><br>3. Review of the plan of care, for the certification period 4/6/23 – 6/04/23, completed by RN 4, included a summary of Patient and relayed Patient #6 had clear breath sounds with rhonchi (sounds like snoring, indicating fluid in the lower airway), present during the assessment.<br><br>4. During an interview on 6/05/23 at 2:04 PM, the Clinical Supervisor indicated the wound must not be covered to assess | | All nursesresponsible for completing comprehensive patient assessments have beenre-educated on proper documentation of breath sounds and wound status, as wellas the requirement to accurately document the patient's clinical presentationat the time of assessment. This education will continue to be presented to allincoming nurses during the orientation process.<br><br>The DON ordesignated RN will review 100% of comprehensive assessments for 60 days toensure continued compliance with assessment documentation requirements. After60 days of compliance, the DON or designated RN will include a review ofpatient assessments during the 10% quarterly clinical record audit as part ofthe Agency's QAPI program to ensure compliance is maintained.<br><br>The DON isresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur. | |

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| | healing status and breath sounds are not clear if rhonchi are present.<br><br>410 IAC 17 - 14 - 1(a)(1)(B) | | Completed 6/30/23 | |
| G0536 | A review of all current medications<br><br>484.55(c)(5)<br><br>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.<br><br>Based on record review and interview, the agency failed to ensure the comprehensive assessment included a medication review to identify potential medication issues requiring physician input in 2 of 6 (Patients #2, #5) active records reviewed, with the potential to affect all patients.<br><br>Findings include: | G0536 | All RNsresponsible for completing medication reviews have been re-educated on therequirement to complete a medication review with each comprehensive assessmentand to ensure the date documented for the medication review in the EMR'smedication profile matches the date that the medication review is documentedwithin the corresponding assessment to properly reflect the date the review wascompleted. This education will continue to be provided to all incoming RNs whowill be responsible for medication reviews.<br><br>The DON ordesignated RN will audit 100% of medication reviews for 60 days to ensure thedocumented review date in the EMR's medication profile matches the date theassessment and medication review were completed. After 60 | 2023-06-30 |

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| | 1. Review of an agency policy titled "Medication Reconciliation C – 709," indicated the purpose of the policy was to prevent potential medication errors. The policy indicated the medications should be reviewed at the start of the patient's care.<br><br>2. Review of an agency policy on comprehensive assessments indicated a medication review was to be completed to identify potential adverse reactions, significant side effects, significant drug interactions, duplicate therapy, and issues with medication compliance.<br><br>3. Review of the clinical record for Patient #2, start of care 10/26/2022, evidenced the medication review was conducted on 11/9/2022, 12 days after the date of the comprehensive assessment.<br><br>4. Review of the clinical record for Patient #5 evidenced a comprehensive assessment dated 4/02/2023; the date of a medication review was 5/09/2023, 16 days later.<br><br>5. During an interview on 5/31/2023 at 4:15 PM, the Clinical Supervisor indicated | | days, the DON or RNdesignee will include an audit of medication reviews in the quarterly 10%clinical record review as part of the Agency's QAPI program to ensure continuedcompliance.<br><br>The DON isresponsible for monitoring these corrective measures to ensure the deficiencyis corrected and will not recur.<br><br>Completed6/30/2023 | |

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| | staff will sometimes complete the medication review a "couple of days" after the comprehensive assessment. The Clinical Supervisor confirmed Patient #2's and Patient #5's medications were reviewed 12 and 16 days respectively after the start of care, indicated was not conducted as part of the comprehensive assessment.<br><br>410 IAC 17 - 14 - 1(a)(1)(B) | | | |
| G0546 | Last 5 days of every 60 days unless:<br><br>484.55(d)(1)(i,ii,iii)<br><br>The last 5 days of every 60 days beginning with the start-of-care date, unless there is a-<br><br>(i) Beneficiary elected transfer;<br><br>(ii) Significant change in condition; or<br><br>(iii) Discharge and return to the same HHA during the 60-day episode.<br><br>Based on record review and interview the agency failed to ensure a recertification comprehensive assessment was conducted during the last 5 days of every 60 days, in 1 of 3 active pediatric records reviewed (Patient #4).<br><br>Findings include:<br><br>Review of an undated agency | G0546 | Therecertification visit for patient #4 was completed on 5/31/23, as soon as itwas noted to have been late. The Physician was notified of the laterecertification, and this communication was documented in the clinical record. Aplan of care for the new certification period was submitted to the Physicianfor signature, and the 4 shifts between the expiration of the priorcertification period and the recertification visit date were excluded frombilling.<br><br>The DONcompleted a 100% audit of the Agency's | 2023-06-30 |

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| | policy titled "Patient Reassessment/Update of Comprehensive Assessment C-155" indicated the comprehensive assessment will be updated and revised the last 5 days of every 60 days.<br><br>Clinical record review of Patient #4 on 05/31/2023 revealed the patient received skilled nurse services on 05/26/2023, 05/28/2023, 05/30/2023 and 05/31/2023 for the administration of medications and tube feeding, and provided caregiver education. The clinical record failed to evidence a comprehensive assessment prior to the end of the plan of care for the certification period ending 5/25/23.<br><br>During an interview on 05/31/2023 at 2:00 PM, the director of clinical services indicated the comprehensive assessment was not conducted.<br><br>410 IAC 17-14-1(a)(1)(B) | | recertification tracker and checked allcertification expiration dates against the EMR. All dates were found to becompliant, and no other recertification visits were found to be late.<br><br>All RNsresponsible for completing recertification assessments have been re-educated onthe requirement to complete the recertification assessment within days 56-60 ofeach certification period, as well as the importance to verify that the visitwindow dates in the recertification tracker match the dates noted in the EMR toensure all recertification assessments are completed timely. This educationwill continue to be presented to all incoming nurses who are responsible forcompleting recertification assessments as part of the orientation and trainingprocess.<br><br>The DON orAdministrator will review the Agency's recertification tracker at least weeklyfor 60 days to ensure all recertification visits are | |

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| | | | completed within therequired window. After 60 days of compliance, the DON will reviewrecertification dates in the 10% quarterly clinical record audit as part of theAgency's QAPI program to ensure compliance is maintained.<br><br>The DON andAdministrator are responsible for monitoring these corrective actions to ensurethe deficiency is corrected and will not recur.<br><br>Completed 6/30/23 | |
| G0570 | Care planning, coordination, quality of care<br><br>484.60<br><br>Condition of participation: Care planning, coordination of services, and quality of care.<br><br>Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result | G0570 | Therecertification assessment and updated plan of care for patient #4 werecompleted and sent to the physician. All Agency patients were reviewed againstthe Agency's recertification visit tracker to confirm that no otherrecertifications were late, and all recertification windows on the tracker wereconfirmed against the EMR to ensure accuracy. The records for patients #3, #4,#5 and #7 have been updated to accurately reflect each patient's | 2023-06-30 |

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| | of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice.<br><br>Based on record review, observation and interview, the home health agency failed to ensure the medical care provided was established in consultation with the attending physician, and within an individualized written plan of care (See G572), failed to ensure the plan of care was individualized and included all pertinent diagnoses and accurate medications (See G574), and failed to notify the physician of changes in the patient need for services (See G590).<br><br>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care for the condition of participation at 42 CFR 484.60 Care planning, coordination, and quality of care. | | medicationsand diagnoses. The Agency reviewed all patient medication profiles and plans ofcare for accuracy of medications and diagnoses. Any needed clarificationchanges have been made and updated physician orders have been obtained and sentfor signature accordingly, and all records are compliant. Missed visit notesfor patient #3 have been sent to the physician and are filed in the clinicalrecord. The Administrator and DON have audited the schedule to identify anypatients who are repeatedly refusing replacement staff or where the scheduleworked deviates from the ordered frequency and duration to ensure there is acase conference with the patient/family and that the MD is informed of anychanges a patient's need for services.<br><br>All RNsresponsible for creating or updating the plan of care have been re-educated onthe requirements to update the plan of care at least every 60 days, based on arecertification assessment completed on days | |

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| | | | allmedications and diagnoses to be accurate according to the patient's currentclinical picture. All Agency staff members have been re-educated on therequirement to notify the MD of any deviations from the plan of care and toreport any changes in a patient's service needs to the physician as soon as theAgency becomes aware of the need. All education will continue to be presentedto incoming RNs and Agency staff as part of the orientation and trainingprocess.<br><br>The DON andAdministrator will audit the schedule weekly for 60 days to ensure compliancewith the requirement to notify the physician of any changes in patients' needfor services. After 60 days of compliance, frequency and duration and changesin a patient's need for services will be reviewed during the quarterly 10%clinical record audit as part of the Agency's QAPI program, to ensurecompliance is ongoing. The DON will review 100% of any new or updated plans ofcare for 60 days to ensure | |

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| | | | requirement to include updatedand correct medication information and diagnoses on the plan of care. After 60days of compliance, plans of care will be reviewed during the quarterly 10%clinical record audit as part of the Agency's QAPI program, to ensure continuedcompliance is maintained.<br><br>The DON andAdministrator are responsible for monitoring these corrective actions to ensurethe deficiencies are corrected and will not recur.<br><br>Completed6/30/2023 | |

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| G0572 | Plan of care<br><br>484.60(a)(1)<br><br>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.<br><br>Based on record review and interview the agency failed to ensure the medical care provided was established in consultation with the attending physician, and within an individualized written plan of care in 1 of 3 active pediatric records reviewed (Patient #4).<br><br>Findings include:<br><br>1. A review of the clinical record review for Patient #4 on 5/31/23 revealed Patient received skilled nurse services on 05/26/23, 05/28/23, 05/30/23 and 05/31/23 for the administration of medications and tube feeding, and caregiver education. The clinical record | G0572 | The recertificationvisit for patient #4 was completed on 5/31/23. The Physician was notified ofthe late recertification, and a verbal order for recertification was obtainedprior to updating the plan of care, which was then submitted to the Physicianfor signature. The 4 shifts between the expiration of the prior certificationperiod and the recertification visit date were excluded from billing.<br><br>Patient #3smissed visits were sent to the physician for notification of all missed shifts,and this documentation is present in the clinical record.<br><br>The DONcompleted a 100% audit of the Agency's recertification tracker and checked allcertification expiration dates against the EMR. Audit findings indicated therewere no plans of care created prior to obtaining the physician order. TheAgency confirmed that missed visit notifications continue to be sent to themanaging physician/provider at least weekly for any missed visits that | 2023-07-09 |

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| | nor written or verbal orders for the medical care provided.<br><br>During an interview on 5/31/23 at 2:00 PM, the director of clinical services indicated they had not contacted the attending physician nor developed a plan of care, nor do they have physician orders for the care provided after 5/25/23.<br><br>2. A clinical record review of Patient #3, included a plan of care for the certification period 04/11/2023 to 06/09/2023 with orders for home health aide services 1/2 to 4 hours a day, 1-3 days a week, and for 4-8 hours a day, for 4-6 days a week for 9 weeks. The clinical record failed to evidence home health aide visits were provided as ordered.<br><br>Review of agency documents titled "Client Logging Report" included documentation that the agency could not provide staff for the ordered home health aide visits from 04/04/2023 to 05/20/2023.<br><br>During an interview on 6/05/23 at 2:04 PM, the administrator indicated the last home health aide visit for Patient #3 was | | resultin deviation from the ordered frequency and duration. The DON and Administratorwill review any patients who routinely decline care or have inconsistentstaffing and will hold case conferences with those patients and the orderingphysician to determine appropriate steps to be taken. These conversations willbe documented in the clinical record.<br><br>All RNsresponsible for completing recertification assessments have been re-educated onthe requirement to update the plan of care within days 56-60 of eachcertification period after obtaining the verbal order from the physician tocontinue care, as well as the importance to verify that the visit window datesin the recertification tracker match the dates noted in the EMR to ensure allrecertification assessments and corresponding plans of care are completedtimely and in consultation with the physician. This education will continue tobe presented to all incoming nurses who are responsible for | |

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| | made on 4/01/23 and no further. The director of clinical services indicated the agency thought another daughter of Patient would be hired to provide the ordered home health aide services, which did not occur. | | completingrecertification assessments as part of the orientation and training process.Agency staff members have been re-educated on proper documentation of missedvisits and physician notification, as well as the need to initiate caseconferencing for repeated declination of services or schedule inconsistencies.This education will continue to be provided to all incoming staff members aspart of the orientation process.<br><br>The DON orAdministrator will review the Agency's recertification tracker at least weeklyfor 60 days to ensure all recertification visits are completed within therequired window and the plan of care is updated after obtaining physicianorders. After 60 days of compliance, the DON will review recertification datesin the 10% quarterly clinical record audit as part of the Agency's QAPI programto ensure compliance is maintained. The Administrator and DON will reviewmissed visit notes weekly for 60 days to ensure physicians | |

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| | | | missed services and case conferences are held appropriately. After 60 days,the Administrator and DON will review missed visits during the quarterlyclinical record audit as part of the Agency's QAPI program to ensure complianceis maintained.<br><br>The DON andAdministrator are responsible for monitoring these corrective actions to ensurethe deficiency is corrected and will not recur.<br><br>Completed 7/9/23 | |
| G0574 | Plan of care must include the following<br><br>484.60(a)(2)(i-xvi)<br><br>The individualized plan of care must include the following:<br>(i) All pertinent diagnoses;<br>(ii) The patient's mental, psychosocial, and cognitive status;<br>(iii) The types of services, supplies, and equipment required;<br>(iv) The frequency and duration of visits to be made;<br>(v) Prognosis; | G0574 | The clinicalrecords for patients #3, #4, #5 and #7 have been corrected to identify theproper medication administration route and to ensure all pertinent diagnosesare present on the plan of care. The Agency reviewed all patient medicationprofiles and plans of care for accuracy of medications and diagnoses. Anyneeded clarification changes have been made and updated physician orders havebeen sent accordingly, and all records are | 2023-06-30 |

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| | (vi) Rehabilitation potential;<br><br>(vii) Functional limitations;<br><br>(viii) Activities permitted;<br><br>(ix) Nutritional requirements;<br><br>(x) All medications and treatments;<br><br>(xi) Safety measures to protect against injury;<br><br>(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.<br><br>(xiii) Patient and caregiver education and training to facilitate timely discharge;<br><br>(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;<br><br>(xv) Information related to any advanced directives; and<br><br>(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.<br><br>Based on record review, interview, and observation the agency failed to ensure the plan of care was individualized and included all pertinent diagnoses and accurate medications for 4 of 7 patient records reviewed (Patient #3, 4, 5, 7).<br><br>Findings include: | | compliant.<br><br>All RNsresponsible for creating and updating the plan of care have been re-educated onthe importance of ensuring the plan of care contains accurate, patient-specificinformation. This education will continue to be presented to all incoming RNswho will be responsible for creating and updating the plan of care as part of thetraining process.<br><br>The DON ordesignated RN will review 100% of new and updated plans of care for 60 days toensure continued compliance with the requirement to ensure medications anddiagnoses are accurate and updated. After 60 days of compliance, the DON or RNdesignee will review plans of care during the 10% quarterly clinical recordaudit as part of the Agency's QAPI program to ensure compliance is maintained.<br><br>The DON isresponsible for | |

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| | Review of an agency policy titled "Plan of Care C – 580" indicated the plan of care is developed based on the current assessment of the patient and must include all pertinent diagnoses and medications, including dosage and route of administration.<br><br>Review of the clinical record for Patient #5, certification period 4/24/2023 – 6/22/2023, evidenced a plan of care which identified a diagnosis of spastic quadriplegic cerebral palsy (a disorder affecting muscles and movement of all four limbs, face, and torso). No other diagnoses were identified.<br><br>Review of clinical information from Entity A included documentation of Patient #5's diagnoses of spastic quadriplegic cerebral palsy, pancreatic cyst, constipation, gastroesophageal reflux disorder (GERD), intellectual disability, severe osteoporosis, and the presence of a gastrostomy tube (a tube inserted into the stomach that brings nutrition and medication directly to the stomach). Documentation included history | | monitoring these corrective actions to ensure the deficiency iscorrected and will not recur.<br><br>Completed6/30/23 | |

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| | recurrent bouts of pneumonia, and recurrent abdominal abscesses.<br><br>During an interview on 6/1/2023 at 3:55 PM, the Clinical Supervisor indicated the plan of care was missing pertinent diagnoses that could impact Patient #5's care.<br><br>Review of an agency policy dated 12/30/2022 and titled "Plan of Care C-580" indicated the plan of care will include all pertinent diagnoses and all medications.<br><br>Review of an agency policy dated 12/30/2022 and titled "Physician Orders C-635" indicated all orders for medications must include the route of administration. | | | |

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| | Clinical record review of Patient #3 revealed the plan of care for the certification period of 04/11/2023 to 06/09/2023 indicated the oral route for administration of cyanocobalamin solution (treats Vitamin B12 deficiency) that failed to evidence the correct route as intramuscular (injection into a muscle).<br><br>During an interview on 06/05/2023 at 11:40 AM, the director of clinical services indicated the route of administration should be intramuscular.<br><br>Clinical record review of Patient #4 revealed the plan of care for the certification period of 03/27/2023 to 05/25/2023 that indicated the pertinent diagnosis of dependence on a ventilator (machine that moves air in and out of the lungs).<br><br>During an observation visit with Patient #4 on 05/31/2023 at 10:00 AM, observed a stoma (surgical opening) on the front of patients' neck without tubing that would be connected to a ventilator machine. Registered nurse (RN) 3 indicated the | | | |

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| | January of 2023 and was never replaced.<br><br>During an interview on 05/31/2023 at 4:25 PM, the director of clinical services indicated would remove a diagnosis from the plan of care that was no longer applicable for a patient.<br><br>410 IAC 17-13-1 (a)(1)(C), 17-13-1 (a)(1)(D)(ix) | | | |
| G0590 | Promptly alert relevant physician of changes<br><br>484.60(c)(1)<br><br>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.<br><br>Based on record review and interview, the agency failed to notify the physician of changes in the patient need for services for 1 of 1 discharged patient records reviewed (Patient #3).<br><br>Findings include:<br><br>Review of an agency policy dated 12/30/2022 and titled | G0590 | Missed visitnotifications for patient #3 have been sent to the physician and are documentedin the patient's clinical record. The Agency has confirmed that missed visitnotifications continue to be sent to the managing physician/provider at leastweekly for all patients for any missed visits that result in deviation from theordered frequency and duration, and the missed visit notes are subsequentlyfiled in the corresponding patient's clinical record. The DON and Administratorwill review any patients who routinely decline care or have inconsistentstaffing | 2023-06-30 |

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| | "Plan of Care C-580" indicated professional staff will promptly report to the physician any changes that suggest a need to alter the plan of care.<br><br>Clinical record review of Patient #3, included a plan of care for the certification period 04/11/23 to 06/09/23, with orders for aide visits. The record failed to evidence home health aide visits were provided after 04/01/23. The clinical record evidenced the patient was discharged on 5/25/23.<br><br>Review of home health aide visits indicated the last visit made was on 04/01/23 for 2 hours by home health aide (HHA) 1. Documentation failed to evidence notification to the physician that Patient was not receiving home health aide services, as ordered.<br><br>During an interview on 6/05/23 at 2:04 PM, the administrator indicated the last home health aide visit for Patient #3 was made on 4/01/23 and no further. The director of clinical services indicated the agency thought another daughter of Patient would be hired to provide the ordered home | | and will hold case conferences with those patients and the orderingphysician to determine appropriate steps to be taken. These conversations andany resulting changes in a patient's need for services will be ordered by thephysician and documented in the clinical record.<br><br>TheAdministrator and DON will audit the schedule weekly for 60 days to 100%compliance with the requirement to ensure physicians are notified of declined ormissed visits and case conferences are held appropriately for necessary changesto the plan of care or to address persistent declination of service or deviationfrom the ordered frequency and duration. After 60 days of compliance, theAdministrator and DON will review frequency and duration and missed visitsduring the quarterly clinical record audit as part of the Agency's QAPI programto ensure compliance is maintained.<br><br>TheAdministrator and DON are | |

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| | health aide services.<br><br>410 IAC 17-13-1 (a)(2) | | responsible for monitoring these corrective actionsto ensure the deficiency is corrected and will not recur.<br><br>Completed6/30/23 | |
| G0682 | Infection Prevention<br><br>484.70(a)<br><br>Standard: Infection Prevention.<br><br>The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.<br><br>Based on record review, observation, and interview, the agency failed to ensure staff used proper hand hygiene (handwashing or use of alcohol based hand rub) to prevent the spread of infection in 1 of 2 skilled nurse home visit observations (Registered nurse (RN) 2, and with the potential to affect all patients in which RN 2 provided direct care or supervised direct care.<br><br>Findings include:<br><br>1. Review of an agency policy on hand hygiene, indicated hand hygiene must be completed prior to providing patient care and before putting | G0682 | All Agencyemployees, including RN #2, have been re-educated on infection controlprecautions on , including proper handwashing related to donning gloves. Allincoming employees will continue to receive this education during theorientation and training process, prior to the provision of patient care.<br><br>The Director of Clinical Services or designated RN willobserve handwashing and gloving procedures during every in-home supervisory orrecertification visit on an ongoing basis, and this observation will bedocumented in the supervisory component of each visit note. Every employeeperforming patient care will have an annual competency assessment conducted byan RN, specific to | 2023-07-09 |

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| | on gloves.<br><br>2. During a home observation visit of RN 2, during the provision of direct care with Patient #2 on 5/31/23, RN 2 used a catheter to suction (insertion of a tube to remove thick mucus from the trachea) Patient. Prior to performing the procedure, RN 2 failed to complete hand hygiene (no handwashing or use of an alcohol based hand rub) prior to donning gloves.<br><br>During an interview at the visit, RN 2 indicated she did not realize she did not complete hand hygiene.<br><br>3. During an interview on 6/2/2023 at 12:47 PM, the Clinical Supervisor indicated hand hygiene (handwashing or the use of an alcohol based hand rub) was to be performed before providing care to the patient as well as before putting on gloves.<br><br>410 IAC 17 - 12 - 1(m) | | infection control, including hand hygiene and glovingpractices, to ensure employees remain compliant with practicing properinfection control measures. This competency assessment will be conducted eitherin a patient home setting or in the office skills lab and will be evidenced ineach employee's file.<br><br>To ensure ongoing compliance, the Administrator or designeewill review at least 10% of employee files quarterly to verify completion ofthe initial and annual competency assessment as part of the Agency's QAPIprogram.<br><br>The Administrator and DON are responsible for monitoringthese corrective actions to ensure the deficiency is corrected and will notrecur.<br><br>Completed 7/9/23 | |
| G0706 | Interdisciplinary assessment of the patient<br><br>484.75(b)(1) | G0706 | LPN #1, #2 and#3 were all reeducated on the requirement to notify the supervising RN of anypatient changes discovered | 2023-07-09 |

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| | Ongoing interdisciplinary assessment of the patient;<br><br>Based on record review and interview, the agency failed to ensure the licensed practical nurse (LPN) completed an assessment, as part of the interdisciplinary team, with an accurate representation of the patient's status in 2 of 4 (Patients #5, 6) active patients who received LPN care, with the potential to affect all patients receiving care from an LPN.<br><br>Findings include:<br><br>1. Review of an agency wound policy indicated wound assessments should include the location, size, color, status of the wound edges, and type of new skin growth.<br><br>2. Review of the clinical record for Patient #5, with start of care 4/24/2023, evidenced documentation of a nurse visit performed by licensed practical nurse (LPN) 1 on 5/5/2023, which identified an open area of skin on Patient #5's left buttock. The clinical record failed to include documentation of notification to the registered nurse regarding this finding.<br><br>The clinical record evidenced LPN 2 performed the skilled | | during an assessment, the inability to document awound status if the wound is documented as "not observable" and the requirementto ensure that each assessment is thorough, clearly documented and contains asmuch detail as is necessary to paint a clear clinical picture of the patient atthe time of the assessment. All Agency LPNs and supervising RNs have receivedthis re-education. Additionally, LPN #1 and #3 identified in the survey haveundergone a new competency evaluation for completion and documentation ofpatient assessment as of 7/7/2023. This competency evaluation has been added toeach LPN's personnel record. LPN #2 has been removed from the schedule andnotified that she cannot resume working until her new competency evaluation canbe completed and documented.<br><br>Education andcompetency verification of proper assessment and documentation requirementswill continue to be part of the Agency's orientation | |

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| | nurse visits prior to and after LPN 1's visit; LPN 2's visit notes failed to identify the open wound.<br><br>Review of a skilled nurse visit note, dated 5/11/2023, indicated LPN 2's skilled nurse visit was 9 hours in length with Patient #5; the visit ended at 3:30 PM. The visit note included documentation of a low - grade fever of 99.4 Fahrenheit; other findings were documented as normal.<br><br>Review of clinical documentation from Entity A, dated 5/11/23, indicated Patient arrived at the Emergency Room (ER) on 5/11/2023 at 6:36 PM, 3 hours after LPN 2 left their shift. Patient #5 arrived at the ER with a fever (102 F), respiratory failure (increased oxygen demand), high pulse rate, low blood pressure, and pain (symptoms of sepsis, an overwhelming response to infection that can cause organ failure and death). Patient #5 was admitted to the hospital with diagnoses of sepsis, pneumonia, abdominal abscess (a pocket of infection), possible pancreatic abscess, and a possible femur (thigh) fracture. | | and training process forall incoming nurses.<br><br>The DON or RNdesignee will review 100% of the visit notes for LPNs #1, #2 and #3 for aperiod of 60 days to ensure compliance with assessment documentation andadherence to the plan of care is maintained. The DON or RN designee will review15% of additional LPN visit notes during the 60-day period to ensure compliancewith these requirements. Additional one-on-one education and performance plansmay be implemented by the DON as needed, based on these reviews. After 60 daysof compliance, the DON or RN designee will review visit notes during thequarterly 10% clinical record audit as part of the Agency's QAPI program, toensure ongoing compliance.<br><br>The DON isresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur. | |

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| | LPN 2 failed to identify and document symptoms other than a low - grade fever.<br><br>3. Review of a nursing visit note for Patient #6, completed by LPN 3 on 4/04/2023, indicated the healing status of a surgical wound, including type of skin growth, however the note indicated the wound was not visible as it was covered with a dressing.<br><br>4. During an interview on 6/01/2023 at 3:55 PM, the Clinical Supervisor indicated LPN 2 should have recognized Patient # 5's symptoms.<br><br>5. During an interview on 6/05/2023 at 2:04 PM, the Clinical Supervisor indicated the wound must not be covered with a dressing to assess healing status.<br><br>410 IAC 17 - 12 - 2(g) | | Completed 7/9/23 | |
| G0710 | Provide services in the plan of care<br><br>484.75(b)(3)<br><br>Providing services that are ordered by the physician or allowed practitioner as indicated | G0710 | The clinicalrecord for patient #6 has been updated to reflect the care documented, and anupdated order was sent to the physician for signature. LPN #3 has beenre-educated on the | 2023-06-30 |

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| | in the plan of care;<br><br>Based on record review and interview, the agency failed to provide services, ordered by the physician and as indicated within the plan of care for 1 of 6 records reviewed (Patient # 6) with skilled nurse services.<br><br>Findings include:<br><br>Review of the clinical record for Patient #5, start of care 4/24/2023, evidenced a coordination note dated 5/3/2023, which documented a verbal physician order to resume care for the patient following hospitalization. Review of the comprehensive assessment dated 5/2/2023 confirmed care was provided without a physician order.<br><br>Review of the coordination note dated 5/31/2023 at 2:40 PM indicated a verbal physician order was received to continue care. Review of a revision to the plan of care indicated Patient #5 was discharged home on 5/30/2023 and care was provided on 5/30/2023, one day before the verbal order was obtained.<br><br>Review of Patient #5's plan of care evidenced an order for the | | requirement to only provide patient care in accordance withphysician orders and to notify the Agency immediately if a patient's ordersneed to be revised in collaboration with the patient/patient's representativeand ordering provider. All Agency LPNs have been re-educated on the requirementto adhere to the physician ordered plan of care and to report any neededmodifications to the Agency immediately.<br><br>This educationwill continue to be presented to all incoming nurses during the orientation andtraining process. The DON or RN designee will review 100% of LPN #3's visitnotes for 60 days to ensure continued compliance with documentation against theplan of care. After 60 days of compliance, the DON or RN designee will includea review of nursing visit notes during the 10% quarterly clinical record auditas part of the Agency's QAPI program, to ensure compliance is maintained. | |

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| | supervisory visits every 30 days.<br><br>Review of the clinical record for Patient #6, certification period 4/6/2023 – 6/4/2023, evidenced a verbal physician order to resume care dated 4/4/2023. Review of the comprehensive assessment dated 4/3/2023 confirmed care was provided without a physician order.<br><br>Review of nursing visit notes, completed by licensed practical nurse (LPN) 3, indicated postural drainage (positioning patient so airway secretions are removed by gravity) was completed. Licensed Practical Nurse 3 performed this procedure on 4/4, 4/5, 4/6, 4/7, 4/10, 4/18, 4/19, 4/20, 4/24, 4/25, 4/26, 4/27, 5/1, 5/2, 5/3, 5/4, 5/8, 5/9, 5/10, 5/11, 5/22, 5/23, 5/24, 5/25, 5/30, and 5/31/2023.<br><br>Review of the plan of care for Patient #6 failed to evidence an order for postural drainage.<br><br>During an interview on 6/5/2023 at 2:39 PM, the Clinical Supervisor confirmed LPN 3 completed the procedure without a physician order.<br><br>Review of nursing visit notes for | | The DON isresponsible for monitoring these corrective measures to ensure the deficiencyis corrected and will not recur.<br><br>Completed6/30/23 | |

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| | 4/5 and 4/6/2023, indicated LPN 3 completed wound care on Patient #6's surgical wound. Review of the record failed to identify a physician order for wound care.<br><br>During an interview on 6/5/2023 at 2:39 PM, the Clinical Supervisor confirmed there were no physician orders to provide wound care.<br><br>410 IAC 17 - 14 - 1(a)(1)(H)<br><br>410 IAC 17 - 14 - 1(a)(2)(F)<br><br>Review of an undated RN job description indicated the RN provides skilled nursing care in accordance with physician orders and the plan of care.<br><br>Review of an undated licensed practical nurse (LPN) indicated the LPN provides skilled nurse care in accordance with physician orders and the plan of care.<br><br>Review of an agency policy dated 12/30/2022 and titled "Physician Orders C-635" | | | |

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| | indicated all medications, treatments and services provided to patients must be ordered by a physician.<br><br>Clinical record review of Patient #3, included the plan of care for the certification period 04/11/2023 to 06/09/2023 that indicated orders for home health aide service for .5 to 4 hours a day, 1-3 days a week, and for 4-8 hours a day, for 4-6 days a week for 9 weeks.<br><br>Review of agency documents titled "Client Logging Report" included documentation that indicated the agency could not provide staff for the ordered home health aide visits from 04/04/2023 to 05/20/2023. Documentation failed to evidence the agency provided services according to the plan of care.<br><br>Clinical record review of Patient #4, included a plan of care for the certification period 03/27/2023 to 05/25/2023 that indicated orders for skilled nurse services for 6-10 hours a day, for 4-6 days a week.<br><br>Record review failed to evidence a revised plan of care for the certification period | | | |

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| | beginning 05/26/2023. Review of skilled nurse visits indicated visits were made on 05/26/2023, 05/28/2023, 05/30/2023, and 05/31/2023 with no physician orders. Documentation failed to evidence services were provided according to a plan of care.<br><br>During an interview on 05/31/2023 at 2:16 PM, when asked to see the physician orders to provide care to Patient #4, the director of clinical services indicated a nurse will go out today to complete a comprehensive assessment and then obtain a physician order to revise the plan of care with a retroactive order to be effective on 05/26/23.<br><br>410 IAC<br><br>17-14-1 (a)(1)(H)<br>17-14-1(a)(2)(F) | | | |
| G0726 | Nursing services supervised by RN<br><br>484.75(c)(1)<br><br>Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). | G0726 | A supervisory visithas been completed for patient #5 identified in the survey, and the Agency'ssupervisory tracker has been updated to ensure that this patient's supervisoryvisits fall within the appropriate | 2023-06-30 |

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| | Based on record review and interview, the registered nurse (RN) failed to supervise the care provided by the licensed practical nurse (LPN) for 1 of 6 active records reviewed (Patient # 5).<br><br>Findings include:<br><br>Review of an agency policy titled Supervisory Visit of Patient/ Staff C – 315 indicated the purpose of the visit was to ensure staff were competent in identifying and responding to patient needs.<br><br>Review of the clinical record for Patient #5, start of care 4/24/2023, failed to evidence the licensed practical nurses (LPNs) received supervisory visits, in which the registered nurse (RN) ensured the LPN was providing appropriate care based on the plan of care. When the last supervisory visit note was requested, the Clinical Supervisor provided one dated 3/22/2023.<br><br>During an interview on 6/2/2023 at 9:14 AM, the Clinical Supervisor confirmed supervisory visits were not done.<br><br>Review of the employee record for LPN 2 evidenced an annual | | timeframes moving forward.<br><br>The Agency'ssupervisory visit tracker was audited to confirm supervisory dates of 100% ofpatients, and all visit timeframes were found to be compliant. The supervisoryvisit calculator was adjusted for all skilled patients, regardless of thepresence of RN-only care, to ensure that each skilled patient's schedule isreviewed for LPN care at least every 30 days and a supervisory visit isperformed by an RN accordingly.<br><br>Moving forward,the DON or designated RN will audit the Agency's supervisory visit tracker atleast weekly to ensure all patient visits are made in accordance withregulation and Agency policy. The DON or designated RN will continue to includea review of supervisory visits during the quarterly clinical record audit aspart of the Agency's QAPI program to ensure compliance is maintained. | |

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| | performance evaluation signed by LPN 2 on 3/6/2023. The evaluation was completed by an administrative staff person with no nursing education. The annual performance evaluation signed by LPN 2 on 2/25/2022 was completed by an administrative staff person with no nursing education. The record contained a competency form to assess LPN 2's clinical skills, dated 3/21/2021. The form included LPN 2's initials and signature but did not provide evidence of observation or education by an RN. There were no RN initials for the individual clinical skills and the form was not signed by an RN.<br><br>During an interview on 6/1/2023 at 3:55 PM, the Clinical Supervisor confirmed the agency has a quality review of notes but once the staff person documents well, they are not reviewed any longer. The Clinical Supervisor confirmed LPN 2's notes have not been reviewed and lack clinical elements.<br><br>401 IAC 17 - 14 - 1(a)(1)(J)<br><br>Review of an undated LPN job | | The DON isresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur.<br><br>Completed 6/30/23 | |

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| | provides skilled nursing care under the supervision of the RN.<br><br>Clinical record review of Patient #1, included the plan of care for certification period 04/10/2023 to 06/08/2023 that indicated skilled nurse services for 6.5-10.5 hours a day, for 3-5 days a week, and for 5.5-9.5 hours a day, for 1-2 days a week. The plan of care indicated the RN to perform supervisory visits at least once every 30 days unless RN only care has been provided.<br><br>Record review of skilled nurse visits made during the 04/10/2023 to 06/08/2023 certification period indicated LPN visits were made on 04/20/2023 and 05/07/2023. Documentation failed to evidence the RN supervised the LPN during this 60-day period.<br><br>During an interview on 06/01/2023 at 4:30 PM, the director of clinical services indicated the RN did not make an LPN supervisory visit during this time.<br><br>410 IAC 17-14-1 (a)(1)(J) | | | |

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| G1028 | Protection of records<br><br>484.110(d)<br><br>Standard: Protection of records.<br><br>The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164.<br><br>Based on observation and interview, the home health agency failed to ensure patient's personal health information was stored in a locked, secure area in 1 of 1 home health agency.<br><br>Findings include:<br><br>On 05/30/2023 at 10:15 AM, entered the unlocked door to the entrance of the home health agency.<br><br>During a tour of the home health agency office on 05/30/2023 at 11:50 AM, observed a room with no door. Observed patient paper charts on open shelves inside this room.<br><br>During an interview on 05/30/2023 at 11:50 AM, the administrator indicated the front door to the office is locked at the end of the day. Indicated | G1028 | All patientfiles were relocated to a locked file cabinet prior to the survey exit date of6/6/2023. This file cabinet remains locked, with the Administrator holding theonly key. The Administrator or DON confirms that the cabinet is locked at theend of each business day.<br><br>As of 6/26/23, thereis a dedicated, locked file storage room, for which the Administrator and DONwill have the only keys, ensuring continued protection of patient records. TheAdministrator or DON will verify that this room is locked at the end of eachbusiness day to ensure there is no unauthorized access after-hours.<br><br>TheAdministrator and DON are responsible for monitoring these corrective measuresto ensure the deficiency is corrected and will not recur.<br><br>Completed 6/30/23 | 2023-06-30 |

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| | patient paper charts was removed last Friday by the property owner, because the office was being renovated; there was no door to this room. | | | |
| N0000 | Initial Comments<br><br>This survey was a State complaint of a Home Health Agency Provider.<br><br>Survey Dates: May 30, 31, June 01, 02, and 05, 2023<br><br>Complaint: 98819 was investigated; unrelated findings were cited.<br><br>12-month unduplicated skilled census: 156<br><br>QR: 6/21/23 | N0000 | | |
| N0464 | Home health agency administration/management<br><br>410 IAC 17-12-1(i)<br><br>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 | N0464 | N464<br><br>Team Select has revised its TB policy, whichhas been attached to this plan of correction submission. Team Select hasadopted the national standard from National | 2023-07-14 |

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| | documentation as follows:<br><br>(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.<br><br>(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.<br><br>(3) Any person with:<br><br>(A) a documented:<br><br>(i) history of tuberculosis;<br><br>(ii) previously positive test result for tuberculosis; or<br><br>(iii)completion of treatment for tuberculosis; or<br><br>(B) newly positive results to the tuberculin skin test;<br><br>must have one (1) chest rediograph to exclude a diagnosis of tuberculosis.<br><br>(4) After baseline testing, tuberculosis screening must:<br><br>(A) be completed annually; and<br><br>(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).<br><br>(5) Any person having a positive finding on a tuberculosis evaluation may not:<br><br>(A) work in the home health agency; or<br><br>(B) provide direct patient contact;<br><br>unless approved by a physician to work.<br><br>(6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:<br><br>(A) working for the home health agency; or | | Tuberculosis ControllersAssociation, NTCA in the creation of this policy. Sections 11 through 14 of thepolicy specify new hire testing, screening and risk assessment, annualscreening and risk assessment, and initial and annual TB education. All Agencyoffice personnel members have been oriented to this revised policy, and thiseducation will continue to be presented to all incoming staff members duringthe orientation and training process.<br><br>The Administrator will review the personnelfiles for 100% of all newly hired employees for 60 days to ensure that theinitial TB testing and screening process is conducted in accordance with theAgency's TB policy. The Administrator will conduct weekly reviews for allexisting Agency employees for 60 days to ensure all annual TB screening andrisk assessment requirements are completed in accordance with the TB policy. Toensure ongoing compliance is maintained, the Administrator or designee willinclude a review | |

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| | (B) having direct patient contact;<br><br>has had a negative finding on a tuberculosis examination within the previous twelve (12) months.<br><br>Based on record review and interview, the agency failed to ensure employees received a baseline 2 - step tuberculin (TB) skin test or annual risk assessment in 6 of 6 employee records reviewed, with the potential to affect all patients and staff (Registered nurse (RN) 1, 2, and 3, Licensed practical nurse (LPN) 4, certified nurse aide (CNA) 4, and alternate clinical supervisor).<br><br>Findings include:<br><br>1. Review of an undated agency policy titled "Health Screening D-240" indicated an employee without evidence of a negative TB skin test may require a 2 – step TB test. Review of an attachment to the health screening policy, titled "Morbidity and Mortality Weekly," a publication of the Centers for Disease Control and Prevention (CDC), dated 5/17/2019, included a summary of the 2005 CDC guidelines for the prevention of TB.<br><br>2. Review of a CDC TB website, | | of initial and annual TB records during the quarterly 10%personnel audit as part of the Agency's QAPI program.<br><br>The Administrator is responsible formonitoring these corrective actions to ensure the deficiency is corrected andwill not recur.<br><br>Completed 7/14/23 | |

/tb/topic/testing /healthcareworkers.htm, last updated August 30, 2022, provided guidance regarding healthcare employees. The website indicated many states have regulations regarding TB screening. The website indicated baseline TB screening for new employees should include a 2 – step TB test and an individual risk assessment.

3. A review of the personnel file for RN 1 indicated a hire date of 01/30/23; the file evidenced a first – step Mantoux (type of TB test) dated 02/02/23; the file failed to evidence a second – step test was completed, nor evidence of a prior negative TB surveillance history.

4. Record review for RN 2 indicated a hire date of 10/22/22; the record failed to document a 2 – step TB test on hire, nor an annual TB surveillance.

5. Record review for RN 3 indicated a hire date of 7/28/21; the record failed to document a 2 – step TB test on hire nor annual TB surveillance.

6. Record review for LPN 4

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| | the record failed to document a 2 – step TB test on hire, nor an annual TB surveillance.<br><br>7. Record review for CNA 1 indicated a hire date of 5/21/21; the record failed to document a 2 – step TB test on hire, nor an annual TB surveillance.<br><br>8. Record review for the Alternate Clinical Supervisor, no date of hire indicated, failed to evidence documentation of a 2 – step TB test on hire, nor annual TB surveillance.<br><br>9. During an interview on 6/2/2023, the Administrator indicated the agency followed the Centers for Disease Control and Prevention guidelines for TB screening and testing and did not do 2 – step TB tests on hire, nor annual TB surveillance. | | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Jon Rocholl | Administrator | 7/14/2023 10:22:26 AM |