STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157624	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Physiocare Home Healthcare Llc	**1440 INNOVATION PLACE , WEST LAFAYETTE, Indiana, 47906**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: June 19, 20, 21, 22, 23, 26, 27, 28, and July 7,10, and 11, 2023. Unduplicated Skilled Admissions for Previous 12 Months: 539 At this Emergency Preparedness survey, Physiocare Home Health was not found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR 7/20/23 Area 2	E0000		
E0039	EP Testing Requirements CFR(s): 484.102(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or	E0039		

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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E0039	Continued from page 1 (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.	E0039		

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E0039	Continued from page 2 (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E0039		

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E0039	Continued from page 3 (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:	E0039		

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E0039	Continued from page 4 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.	E0039		

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E0039	Continued from page 5 (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is	E0039		

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E0039	Continued from page 6 community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or	E0039		

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E0039	Continued from page 7 prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to conduct exercises to test the	E0039		

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E0039	Continued from page 8 emergency plan at least annually, which had the potential to affect all patients and employees. Findings include: Review of an agency policy titled “Emergency Management Plan,” dated 11/2021, indicated the agency would test their emergency preparedness plan at least annually. The test would include either a facility-based exercise, conducted in the community or individually by the agency, or an analysis of an actual emergency preparedness activation. Review of the agency emergency preparedness plan failed to evidence testing of the emergency preparedness plan. During an interview with the Administrator on 07/11/2023 beginning at 10:35 AM, the Administrator indicated the agency had activated their Emergency Preparedness Plan but failed to document analysis of the activation. The Administrator confirmed the agency had never tested the emergency preparedness plan through an individual or community-based exercise.	E0039		
G0000	INITIAL COMMENTS This was a Federal and State complaint investigation and State Re-License survey of a Deemed Home Health agency. The survey was announced as fully extended on July 7, 2023, at 8:47 AM. Complaint #99313 was investigated, related and unrelated Federal and State findings are cited. Survey Dates: June 19, 20, 21, 22, 23, 26, 27, 28, and July 7, 10, 11, 2023 Unduplicated Skilled Admissions for Previous 12 Months: 539 The agency’s administrator was notified on 6/27/23 at 9:28 AM of an Immediate Jeopardy at 484.60 Condition of participation: Care planning, coordination of services, and quality of care. The Immediate Jeopardy was identified as beginning on 06/14/2023. The agency's Immediate Jeopardy plan and actions were determined to have removed the immediacy component of the Immediate Jeopardy on 6/28/2023 at 11:30 AM. During the survey, Physiocare Home Healthcare was found to be out of compliance with Conditions of Participation 484.60 Care planning, coordination of	G0000		

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G0000	Continued from page 9 services, and quality of care, and 484.75 Skilled Professional Services. Based on these condition-level deficiencies, Physiocare Home Healthcare was subject to a partial or extended survey on July 7, 2023, pursuant to section 1891(c)(2)(D) of the Social Security Act. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, the agency is precluded from providing its own home health aide training and competency evaluation programs for a period of two years beginning July 11, 2023 and continuing through July 10, 2025. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.	G0000		
G0544	Update of the comprehensive assessment CFR(s): 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the comprehensive assessment was updated at time of recertification to reflect the patient's current wound status for 1 of 1 records reviewed of an active patient with a recertification comprehensive assessment (Patient #3). Findings include: Review of agency policy #N-7.02 titled "Pressure Ulcer – Assessment," effective 05/01/2015, indicated pressure ulcer wounds (type of wound caused by prolonged pressure to an area, classified in "stages" from 1 to 4) should be assessed weekly. The policy indicated the wound assessment should include but not be limited to wound classification and/or staging, wound bed color, presence or absence of undermining or tunneling, presence or absence of drainage odor, and surrounding skin appearance. Review of Patient #3's clinical record included a plan of care for the recertification period of 03/25/2023 – 05/23/2023 which indicated patient diagnoses included but were not limited to Stage 2 pressure ulcer wound (classification of pressure ulcer wound where the	G0544		

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G0544	Continued from page 10 damage extends below the outer layers of the skin) to the right and left heel and paraplegia (inability to move the lower body). The plan of care indicated that Patient #3 was to receive skilled nursing services for one visit per week with nursing interventions including but not limited to assessing any skin alterations and/or wounds, monitoring for signs and symptoms of infection, and evaluating wound “healing process and progress.” The record included a comprehensive recertification assessment completed on 05/22/2023 by RN 1. The assessment failed to evidence the nurse’s wound assessments for Patient #3’s right and left pressure ulcers included all aspects of pressure ulcer assessment to agency policy, including wound classification and/or staging, wound bed color, presence or absence of drainage odor, presence or absence of undermining or tunneling, and a description of the surrounding skin appearance. During an interview conducted with the Clinical Supervisor on 06/26/2023 beginning at 4:27 PM, the Clinical Supervisor reported wound assessment documentation should include but not be limited to the wound’s location, classification, measurement, presence or absence of odor and signs/symptoms of infection, wound bed appearance, and the surrounding skin appearance. 410 IAC 17-14-1(a)(1)(B)	G0544		
G0570	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. 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 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.	G0570		

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G0570	Continued from page 11 This CONDITION is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to evaluate for and/or provide services for assistance with personal care needs for 2 of 2 active records reviewed which evidence a need for home health services to assist the patient with personal care needs (Patients #20, 22). Based on observation, record review, and interview, the home health agency failed to ensure the plan of care was individualized and included a complete medication list, all required durable medical equipment (DME) and supplies, patient-specific nutritional requirements, and measurable goals (see Tag G574); agency failed to ensure all verbal orders received by agency personnel were sent to the ordering advanced care practitioner for authentication (see Tag G584); and failed to notify and coordinate care with the patient's advanced care practitioner for a newly observed wound, pain which was not effectively treated, nor for a peripherally inserted central catheter (PICC) which was not producing blood return (see Tag G590). The cumulative effect of these systemic problems indicated the home health agency's was unable to ensure provision of quality health care, which resulted in the agency being found out of compliance for the condition of participation 484.60 Care planning, coordination of services, and quality of care. Findings include: 1. Review of agency policy #1-006 titled "Admission Criteria and Process," last revised 11/2021, indicated patients would be accepted to the agency for home health services on "the reasonable expectation that the patient's medical, nursing, [and] rehabilitative … needs can be adequately met …." The policy also indicated after a patient was admitted for home health services, the agency was "responsible for providing care and services" to the patient. 2. Review of the clinical record for Patient #20 included a referral for home health services, ordered 11/28/2022 by the patient's primary care provider, which indicated the patient was to receive skilled nursing, occupational therapy, physical therapy, and home health aide services. The record included an initial comprehensive assessment, completed by Former Registered Nurse (RN) 2 on 11/30/22, which indicated Patient #2 had diagnoses including but not limited to heart failure, COPD (Chronic Obstructive Pulmonary Disease, a progressive lung disease), lung cancer with spread to the colon and liver, and fibromyalgia. The	G0570		

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NAME OF PROVIDER OR SUPPLIER: Physiocare Home Healthcare Llc	STREET ADDRESS, CITY, STATE, ZIP CODE: 1440 INNOVATION PLACE , WEST LAFAYETTE, Indiana, 47906		

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G0570	Continued from page 12 assessment indicated the patient’s functional limitations included incontinence (inability to control a person’s bowel movements and/or urination), endurance, and indicated the patient became short of breath with minimal exertion, the “Sensory” section indicated the patient had arthritis, weakness, joint pain, and decreased range of motion, and the “Pain” assessment indicated Patient #20' pain interfered “all of the time” with the patient’s activity and/or movement. The assessment’s evaluation of Patient #20's ability to perform of ADLs (activities of daily living, skills required to care for oneself, including bathing, toileting, eating, etc) indicated the patient needed a caregiver to assist with grooming, getting dressed, toileting, ambulating, and getting their meals set up. The assessment also indicated the patient was unable to shower or bathe in a tub and required assistance with a bed bath. The record failed to evidence Former RN 2 recognized Patient #20 had a need for home health care services to assist with their personal care needs. The record included a plan of care for the initial certification period of 11/30/2022 – 01/28/2023 which failed to evidence Patient #20 was to receive home health aide and/or other home health services to assist with the patient’s personal care needs. The record indicated Patient #20 was discharged from a local hospital on 01/25/2023 and on 01/26/2023 Physical Therapist (PT) 2 completed a resumption of care assessment. The assessment indicated Patient #20 continued to require physical assistance for activities of daily living and had hired a private pay caregiver to assist with their personal care needs. The record failed to evidence the agency evaluated and offered to Patient #20 home health services to assist to their personal care needs. During an interview conducted with PT 2 on 07/11/2023 beginning at 4:17 PM, the therapist confirmed Patient #20 required a caregiver to assist with their personal care needs and the patient received this care through a private pay caregiver and family members. The record included a Journal Note, documented on 02/01/2023 by PT 2, which indicated the therapist spoke with Family Member 1, a family member of Patient #20, who reported the patient had “declined significantly,” needed increased assistance with transferring, and was unable to bear any weight on their legs. The note also indicated PT 2 had received an order for skilled nursing and social work services to assist with the patient’s needs due to their declining health.	G0570		

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G0570	Continued from page 13 The record included a skilled nurse visit note completed on 02/01/2023 by Former RN 2. The visit note indicated the patient's private pay caregiver was assisting with the patient's personal care needs every day, including bathing. The record included a Journal Note, documented on 02/03/2023 by Medical Social Worker (MSW) 1, which indicated the social worker spoke with Family Member 1 regarding Patient #20 and their family's "needs and difficulties" in caring for the patient. The family member reported another family member was doing "90% of the work" in assisting Patient #20 with personal care needs and was overwhelmed. The record included a social work evaluation visit conducted on 02/06/2023 by MSW 1. The visit note indicated the referral for social work included "education on level of care and caregiving services." The note indicated Patient #20 had an altered ability to ambulate, required assistance with ADLs, and required meal preparation and feeding assistance. The note also indicated Family Member 1 reported the family was "overwhelmed" with the patient's caregiving needs and wanted additional help. The record failed to evidence MSW 1 obtained an order for home health aide services and/or additional home health services to assist with the patient's personal care needs. During an interview with MSW 1 on 07/11/2023 beginning at 11:09 AM, the social worker confirmed they did not discuss nor offer home health aide services to Patient #20's family due to the agency not having home health aides available. During an interview with Family Member 1 on 07/11/2023 beginning at 8:16 AM, the family member confirmed the home health agency had not offered home health aide services nor other home health services to assist with Patient #20's personal care needs. The family member also confirmed Patient #20's family had to hire a private duty caregiver to assist with the patient's personal care needs. During an interview with the Clinical Supervisor conducted on 07/11/2023 beginning at 2:30 PM, the Clinical Supervisor confirmed the agency did not offer home health aide services or any other home health services to assist with Patient #20's personal care needs. 3. Review of the clinical record for Patient #22 included plans of care for the initial certification period 05/05/2023 - 07/03/2023 and recertification	G0570		

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G0570	Continued from page 14 period 07/04/2023 - 09/01/2023 which indicated the patient diagnoses included but were not limited to spinal stenosis, lumbosacral region (narrowing of spinal cord compressing the nerves through the lower back into the legs) and left foot drop (difficulty lifting front of foot). The plan of care for the initial certification period indicated order for physical therapy to improve muscle strength and endurance and the plan of care for the recertification period indicated orders for physical therapy to increase muscle strength, endurance and range of motion and orders for occupational therapy. The record included an admission assessment completed on 05/05/2023 by PT 1 indicated the patient needed assistance with bathing, grooming, dressing, and walking, however the therapist documented there was no need for the patient to receive home health aide services. The record failed to evidence the agency offered home health aide services nor other services to assist with the patient's personal care needs. The record included a recertification comprehensive assessment, completed on 07/01/2023 by PT 1, which indicated the patient required home health aide assistance for personal care needs including but not limited to bathing, grooming, dressing, and walking. The record indicated Patient #22 received assistance from their assisted living facility (ALF) staff and had recently increased the level of care provided by the ALF. The record failed to evidence the agency offered home health aide and/or other home health services to assist with the patient's personal care needs. During a home visit conducted on 07/10/2023 beginning at 10:15 AM with Patient #22, the patient reported they only received physical therapy services from the agency. PT 1 reported the patient's assistance level provided by ALF staff had increased due to patient falls and decreased leg strength. During an interview on 07/10/2023 at 3:30 PM, when asked if home health aide assistance was offered to Patient #22, PT 1 reported the home health agency did not have a home health aide on staff. PT 1 confirmed Patient #22 was paying for more assistance from the ALF for an increase in level of care provided by their staff to assist the patient with their personal care needs. 410 IAC 17-13-1(a)	G0570		
G0574	Plan of care must include the following	G0574		

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G0574	Continued from page 15 CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the plan of care was individualized and included a complete medication list, all required durable medical equipment (DME) and supplies, patient-specific nutritional requirements,	G0574		

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G0574	Continued from page 16 and measurable goals for 11 of 11 active records reviewed (Patients #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 22). Findings include: 1. Review of agency policy #1-007 titled “Care Planning Process,” revised 05/2022, indicated the plan of care should be individualized, patient-specific, and include “measurable outcomes and goals … nutritional requirements … medications and treatments … supplies and equipment required ….” 2. Review of Patient #1’s clinical record included a plan of care for the initial certification period of 06/15/2023 – 08/13/2023. The plan of care indicated the agency’s goals for Patient #1 included but were not limited to “Cardiopulmonary: Patient will demonstrate improved symptom management as evidenced by vital signs with normal limits, improved endurance, decreased [shortness of breath] by the end of 9 weeks … Patient will report pain is controlled or MD will be contacted for further pain management during [certification] period ….” The plan of care failed to evidence the patient’s “normal limits” for vital signs (group of measurements used to assess the general health of a patient, including blood pressure, heart rate, temperature, respiratory rate, and oxygen saturation (SpO2)) and failed to evidence how the patient’s pain would be measured as “controlled.” 3. Review of Patient #2’s clinical record included a plan of care for the initial certification period of 06/13/2023 – 08/01/2023. The plan of care indicated the agency’s goals for Patient #2 included but were not limited to “Patient will report pain is controlled or MD will be contacted for further pain management during [certification] period ….” The plan of care failed to evidence how the patient’s pain would be measured as “controlled.” 4. Review of Patient #3’s clinical record included a plan of care for the recertification period of 05/24/2023 – 07/22/2023. The plan of care indicated the agency’s goals for Patient #3 included but were not limited to “Patient will report pain is controlled or MD will be contacted for further pain management during [certification] period ….” The plan of care failed to evidence how the patient’s pain would be measured as “controlled.” 5. Review of Patient #4’s clinical record included a plan of care for the initial certification period of 05/25/2023 – 07/23/2023. The plan of care indicated the agency’s goals for Patient #4 included but were not	G0574		

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G0574	Continued from page 17 limited to “Patient will report pain is controlled or MD will be contacted for further pain management during [certification] period ….” The plan of care failed to evidence how the patient’s pain would be measured as “controlled.” 6. Review of Patient #5’s clinical record included a plan of care for the initial certification period of 05/19/2023 – 07/17/2023. The plan of care indicated the agency’s goals for Patient #5 included but were not limited to “Cardiopulmonary: Patient will demonstrate improved symptom management as evidenced by vital signs with normal limits, improved endurance, decreased [shortness of breath] by the end of 9 weeks … Patient will report pain is controlled or MD will be contacted for further pain management during [certification] period ….” The plan of care failed to evidence the patient’s “normal limits” for vital signs and failed to evidence how the patient’s pain would be measured as “controlled.” 7. Review of Patient #6’s clinical record included a plan of care for the initial certification period of 06/06/2023 – 08/04/2023. The plan of care indicated the agency’s goals for Patient #6 included but were not limited to “Cardiopulmonary: Patient will demonstrate improved symptom management as evidenced by vital signs with normal limits, improved endurance, decreased [shortness of breath] by the end of 9 weeks … Patient will report pain is controlled or MD will be contacted for further pain management during [certification] period ….” The plan of care failed to evidence the patient’s “normal limits” for vital signs and failed to evidence how the patient’s pain would be measured as “controlled.” 8. Review of Patient #7’s clinical record included a plan of care for the recertification period of 05/05/2023 – 07/03/2023. The plan of care included a medication list which indicated the patient had medication orders for Ondansetron (medication given to treat nausea and/or vomiting) to be given both every 4 hours and every 8 hours as needed for nausea/vomiting, Trazodone (given to treat insomnia and/or depression) to be taken at bedtime as needed for “mood and depression,” Wellbutrin (given to treat depression or assist with quitting smoking) to be given for “smoking cessation,” Hydrocodone-acetaminophen 5 milligrams (mg) – 325 mg (combination of an opioid medication and Tylenol, used to treat pain) twice a day, and Tylenol Extra Strength 500 mg (over-the-counter medication used to treat pain and/or fever), 1-2 tabs every 4 hours as needed. The record also included a “Physician Order Report,” provided by Patient #7’s previous skilled	G0574		

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G0574	Continued from page 18 nursing facility and dated 02/02/2023 – 03/02/2023, which indicated Patient #7 was to take Ondansetron every 8 hours, Trazodone was to be taken for insomnia, the patient was not to take more than 3000 mg of Tylenol in a 24 hour period, and the patient was a former smoker. The plan of care failed to evidence clear directions for the frequency Patient #7 was to take Ondansetron, failed to evidence the correct indication for the patient's Trazodone and Wellbutrin, and failed to evidence the maximum allowed dosage of Tylenol in a 24 hour period. The plan of care indicated the agency's goals for Patient #7 included but were not limited to "Patient will report pain is controlled or MD will be contacted for further pain management during [certification] period …." The plan of care failed to evidence how the patient's pain would be measured as "controlled." 9. Review of Patient #8's clinical record included a plan of care for the initial certification period of 06/08/2023 – 08/06/2023. The plan of care indicated patient diagnoses included but were not limited to Type 2 Diabetes and dysphagia (difficulty swallowing), nursing interventions included but were not limited to "teach diabetic diet," and the patient's personal goal was to "eat without coughing." The plan of care's "nutritional requirements" section failed to evidence Patient #8's needs for a diabetic diet nor patient's difficulty swallowing. The plan of care indicated the agency's goals for Patient #8 included but were not limited to "Cardiopulmonary: Patient will demonstrate improved symptom management as evidenced by vital signs with normal limits, improved endurance, decreased [shortness of breath] by the end of 9 weeks … Patient will report pain is controlled or MD will be contacted for further pain management during [certification] period …." The plan of care failed to evidence the patient's "normal limits" for vital signs and failed to evidence how the patient's pain would be measured as "controlled." 10. Review of Patient #9's clinical record included a plan of care for the initial certification period of 05/10/2023 – 07/08/2023. The plan of care indicated patient diagnoses included but were not limited to Type 2 Diabetes and nursing interventions included but were not limited to "teach diabetic diet." The plan of care's "nutritional requirements" section failed to evidence Patient #8's needs for a diabetic diet. The plan of care indicated the agency's goals for Patient #9 included but were not limited to	G0574		

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G0574	Continued from page 19 “Cardiopulmonary: Patient will demonstrate improved symptom management as evidenced by vital signs with normal limits, improved endurance, decreased [shortness of breath] by the end of 9 weeks … Patient will report pain is controlled or MD will be contacted for further pain management during [certification] period ….” The plan of care failed to evidence the patient’s “normal limits” for vital signs and failed to evidence how the patient’s pain would be measured as “controlled.” 11. Review of Patient #10’s clinical record included a plan of care for the initial certification period of 06/12/2023 – 08/10/2023. The plan of care indicated patient diagnoses included but were not limited to Type 2 Diabetes, nursing interventions including but not limited to “teach diabetic diet,” and the assessment summary indicated the patient had a history of dysphagia. The plan of care’s “nutritional requirements” section failed to evidence Patient #8’s needs for a diabetic diet or history of dysphagia. 12. During a home visit observation conducted on 07/10/2023 beginning at 10:15 PM with Patient #22, Physical Therapist (PT) 1 was observed assisting Patient #22 with application of a left ankle brace. Review of Patient #22’s clinical record included plans of care for the initial certification period of 05/05/2023 - 07/03/2023 and recertification period of 07/04/2023 - 09/01/2023. The plans of care indicated patient diagnosis included but were not limited to left foot drop (difficulty lifting front of foot). The plans of care failed to evidence the use of of a left ankle brace. During an interview with the Clinical Supervisor on 07/11/2023 at 3:25 PM, the Clinical Supervisor confirmed the left ankle brace should be included within the plans of care for Patient #22. 13. During an interview with the Clinical Supervisor on 06/26/2023 beginning at 4:27 PM, the Clinical Supervisor reported staff could assess if the cardiopulmonary goal of a patient demonstrating “improved symptom management as evidence by vital signs within normal limits” by assessing the patient’s blood pressure and/or heart rate over the course of the certification period and comparing to the patient-specific vital sign parameters. The Clinical Supervisor confirmed the plan of care should include patient - specific vital sign parameters and the goal for pain should indicate the patient-specific pain goal.	G0574		

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G0574	Continued from page 20 410 IAC 17-13-1(a)(1)(C)(ii, viii, ix)	G0574		
G0584	Verbal orders CFR(s): 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure all verbal orders received by agency personnel were sent to the ordering advanced care practitioner for authentication for 1 of 1 home visit observations conducted of a patient with whom the agency managed the patient's anticoagulant (blood thinner) testing (Patient #7). Findings include: An agency policy #2-002 titled “Verification of Physician Orders,” last revised 04/2021, indicated when the licensed home health personnel received a verbal order from an advanced care practitioner (doctor, nurse practitioner, etc), a written order would be sent to the advanced care practitioner to authenticate the order by signature. Review of clinical record for Patient #7 included plans of care for the recertification periods of 05/05/2023 – 07/03/2023 and 07/04/2023 – 09/01/2023 which indicated patient diagnoses included but were not limited to long term use of anticoagulant medication, right and left knee joint replacements, and left hip joint replacement. The plans of care indicated Patient #7 was receiving Coumadin (a medication used to slow the time for blood to clot, which decreases the risk of a blood clot forming) and was to receive skilled nursing visits	G0584		

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G0584	Continued from page 21 with nursing interventions including but not limited to obtaining Patient #7's INR level (international normalized ratio, a blood test which calculates how long it takes for the blood to clot and is used to monitor the dosage of warfarin). The plan of care also indicated the nurse was to report the patient's INR level to Local Coumadin Clinic B. A home visit observation was conducted on 07/10/2023 beginning at 8:00 AM with Patient #7. During the visit, Registered Nurse (RN) 1 obtained the patient's INR level. The RN called Local Coumadin Clinic B to report Patient #7's INR level and obtain orders for the patient's Coumadin dose, however the nurse had to leave a message requesting a call back. During an interview conducted with RN 1 on 07/10/2023 beginning at 8:52 AM, the nurse reported when they received a verbal order to adjust the patient's Coumadin dose and/or frequency of skilled nurse visits from Local Coumadin Clinic B, the nurse would send a written verification order to the physician signing the patient's home health orders, who was not associated with Local Coumadin Clinic B. Review of Patient #7's clinical record indicated RN 1 received verbal orders from Local Coumadin Clinic B to adjust the patient's Coumadin dose and/or the frequency of skilled nursing visits on 05/30/2023, 06/19/2023, 06/26/2023, 06/30/2023, and 07/10/2023. The record failed to evidence a written order was sent to Local Coumadin Clinic B to authenticate the verbal order received. The record indicated Licensed Practical Nurse (LPN) 1 received verbal orders from Local Coumadin Clinic B to adjust the patient's Coumadin dose and/or the frequency of skilled nursing visits on 05/09/2023, 05/15/2023, and 06/05/2023. The record failed to evidence a written order was sent to Local Coumadin Clinic B to authenticate the verbal order received.	G0584		
G0590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This ELEMENT is NOT MET as evidenced by:	G0590		

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NAME OF PROVIDER OR SUPPLIER **Physiocare Home Healthcare Llc**	STREET ADDRESS, CITY, STATE, ZIP CODE **1440 INNOVATION PLACE , WEST LAFAYETTE, Indiana, 47906**		

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G0590	Continued from page 22 Based on observation, record review, and interview, the home health agency failed to notify and coordinate care with the patient's advanced care practitioner for a newly observed wound nor pain which was not effectively treated in 1 of 1 skilled nurse home visit observations of a patient with multiple wounds (Patient #3) and failed to notify and coordinate care with the patient's advanced care practitioner for a peripherally inserted central catheter (PICC) which was not producing blood return for 1 of 2 records reviewed of a patient with a PICC line (Patient #13). Findings include: 1. Review of agency policy #1-012 titled "Monitoring Patient's Response/Reporting to Physician," revised 10/2019, indicated the patient's physician or authorized licensed practitioner would be notified "on the same day" when a "significant change" in the patient's condition was identified and all contact and/or attempt to contact the physician would be documented in the patient's clinical record. 2. Review of agency policy #N-7.02 Pressure Ulcer – Assessment, effective 05/01/2015, indicated aftercare for a pressure ulcer wound (type of wound caused by prolonged pressure to a body area, classified in stages from 1 through 4) included "discuss assessment with patient's physician and obtain orders for care." 3. Review of agency policy #N-9.14 titled "Peripherally Inserted Central Catheter (type of IV placed into vein in arm or neck, used for home IV medication and/or infusion administration) Maintenance and Management of Potential Complications, effective 05/01/2015, indicated prior to using a PICC line for blood specimen collection, the skilled professional should attach a syringe filled with saline to the PICC then aspirate (pull back on the attached saline syringe). This would force blood to backflow into the syringe and allow the skilled professional to determine PICC patency. 4. Review of Patient #3's clinical record (start of care 03/30/2022) indicated the patient had a primary diagnosis of a Stage II pressure ulcer (type of pressure ulcer wound where the wound has gone below the outer skin layers) to the right heel and secondary diagnoses including but not limited to Stage II pressure ulcer to the left heel and paraplegia (inability to move the lower part of body). The record included a plan of care for the recertification period 03/25/2023 – 05/23/2023 which indicated the patient was to receive skilled nursing services for 1 visit per week with nursing interventions including but not	G0590		

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G0590	Continued from page 23 limited to assessing for any skin alterations and wounds. The record included a visit note, performed by Former RN 2 on 04/12/2023, which indicated Patient #3 had a “new opening wound” to the “right plantar” (the bottom/posterior part of the foot). The nurse documented they received verbal wound orders from Outpatient Wound Clinic A for the wound to the right plantar metatarsal head (the tip of the bone in the forefoot). The wound was to be cleansed, measured, betadine (type of antiseptic)-soaked gauze was to be applied to the wound bed, then the wound would be covered with gauze, wrapped with Kerlix (gauze roll bandage), and secured with tape. The nurse documented the wound measured 1.4 centimeters (cm) in length by 1.1 cm in width by 0.2 cm in depth. The record included a visit note, performed by Former RN 2 on 04/21/2023, which indicated the wound to Patient #3’s right plantar metatarsal head was healed. The record failed to evidence an assessment of this previous wound site during skilled nursing visit notes documented on 04/28/2023, 05/03/2023, 05/09/2023, 05/17/2023, 05/22/2023, 05/24/2023, 05/31/2023, and 06/07/2023. The record included a visit note, performed by LPN 1 on 05/17/2023, which indicated Patient #3 informed the nurse of pain to their “side” and the patient had contacted their PCP regarding the pain “the other day.” Per the visit note, Patient #3 reportedly stated they were advised by the PCP to take Tylenol (an over-the-counter pain medication) however the Tylenol was ineffective at treating the pain. The record failed to evidence LPN 1 informed the PCP of Patient #3’s ineffective pain relief. The record included a plan of care for the recertification period 05/24/2023 – 07/22/2023 which indicated the patient was to receive skilled nursing visits, 1 time per week, with nursing interventions including but not limited to wound care to a right “plantar” wound, right heel wound, and left heel wound. The plan of care included wound care orders for the right plantar wound which indicated the wound was to be cleansed, betadine-soaked gauze was to be applied to the wound bed, then the wound would be covered with gauze, wrapped with Kerlix, and secured with tape. The wound dressing was to be changed daily. The plan of care summary failed to evidence the presence or absence of a right plantar metatarsal head wound. Review of clinic notes from Outpatient Wound Clinic A,	G0590		

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G0590	Continued from page 24 obtained from the wound clinic, indicated Patient #3 was seen in the office on 06/13/2023. The visit note indicated on this date the patient's "pressure ulcer in the patient's right first metatarsal head" was healed. The visit note also indicated once a day the "healed ulcer" should have petroleum jelly (Vaseline) applied to the site and then be covered with a foam felt dressing. The record included a visit note, performed by RN 1 on 06/14/2023, which indicated Patient #3 had a new wound to the right posterior great toe which did not have any type of dressing on it. The note indicated the nurse told the patient that RN 1 would notify their provider "to see if we can get wound care orders." RN 1 documented the wound was measured but no wound care was performed. The nurse's wound documentation indicated the wound measured 0.8 cm in length by 1.0 cm in width by 0.1 cm in depth. A home visit observation was conducted with Patient #3 on 06/21/2023 beginning at 9:25 AM. During the visit, RN 1 was observed providing wound care to the patient's bilateral heel wounds. The nurse informed the patient of a "new" wound to the right posterior great toe, located approximately between the first and second phalanges bones (the bones of the toe). The wound bed appeared black with 100% eschar. The patient's caregiver had previously placed gauze and tape over the site. RN 1 measured the wound to be 1.6 cm in length by 0.8 cm in width by 0.1 cm in depth. The nurse applied a new dressing of gauze and tape to the site and informed the patient that RN 1 would notify Outpatient Wound Clinic A of the "new" wound and obtain wound care orders. Review of RN 1's visit note from 06/21/2023 indicated Patient #3 had a "new wound to right great toe that has changed in color." An interview was conducted with RN 1 on 06/23/2023 beginning at 12:46 PM, during which the nurse confirmed the right posterior toe wound was first observed during the skilled nurse visit on 06/14/2023. RN 1 reported the wound was a "darker brown" color, closed, and blanchable (turns white when applying pressure to the area). The nurse was unsure of the type of wound. RN 1 stated they thought Patient #3 was due to visit the Outpatient Wound Clinic A the week of 06/19/2023, and since the wound was closed, the nurse did not notify Outpatient Wound Clinic A nor the patient's primary care provider (PCP) of the new wound. RN 1 stated when they returned to see the patient on 06/21/2023, they referred to the right posterior toe wound as "new" since the wound did not have an order for care but the patient's caregiver had applied a dressing. RN 1	G0590		

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G0590	Continued from page 25 confirmed the right posterior toe wound had worsened in measurement and appearance since the 06/14/2023 visit. An interview was conducted with the Administrator on 06/26/2023 beginning at 3:51 PM, during which the Administrator confirmed RN 1 failed to notify Patient #3's primary care provider nor Outpatient Wound Clinic A of the patient's newly developed wound to the right posterior toe and failed to obtain wound care orders. 5. Review of Patient #13's clinical record included a plan of care for the initial certification period of 03/02/2023 – 04/30/2023. The plan of care indicated the patient was to receive skilled nursing services for 1 visit per week with nursing interventions to include but not be limited to perform PICC line dressing changes and obtain laboratory blood specimens. The record included a visit note, completed 03/16/2023 by RN 1, which indicated the patient's PICC line did not have any blood return when the nurse attempted to aspirate. The record failed to evidence RN 1 notified the patient's advanced care practitioner of this change.	G0590		
G0656	Improvements are sustained CFR(s): 484.65(c)(3) The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency's Quality Analysis and Performance Improvement (QAPI) program failed to measure and track performance improvement actions to ensure improvements were sustained, which had the potential to affect all agency patients and employees. Findings include: Review of an agency policy titled "Improving Organizational Performance," dated 10/2019, indicated the agency would adopt a "structured framework" for performance improvement plans and would ensure the performance improvements were maintained. Review of agency documents titled "QAPI Results and PIP (Performance Improvement Plan)" for 3rd Quarter 2022, 4th Quarter 2022, and 1st Quarter 2023 failed to evidence the program measured and tracked performance	G0656		

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G0656	Continued from page 26 improvement plans to ensure improvements resulting from the plans were sustained. During an interview with the agency's QAPI coordinator on 07/11/2023 beginning at 2:15 PM, the QAPI coordinator failed to identify how the agency's QAPI program would measure and determine whether improvements in quality measures resulting from PIPs were or were not sustained. 410 IAC 17-12-2(a)	G0656		
G0682	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure all staff followed agency policies and procedures to prevent the spread of infectious and/or communicable diseases for 5 of 9 home visit observations conducted with 5 of 8 patients ((Patients #1, 2, 3, 4, 5). Findings include: 1. Review of agency policy #7-007 titled “Standard Precautions,” revised 10/2019, indicated hand hygiene should be performed using an alcohol based hand sanitizer or by washing hands with soap and water. The policy indicated staff should change gloves when “between tasks and procedures on the same patient” and “after removing an old dressing.” The policy indicated laboratory specimens should be transported from the patient home to a laboratory in both a “leak-proof container” as well as a “puncture-resistant container that is properly labelled.” The policy also indicated staff should use sterile technique for “IV site care.” 2. Review of agency policy #7-009 titled “Hand Hygiene,” revised 10/2019, indicated when performing hand hygiene with alcohol based hand sanitizer, the employee should rub their hands together until the hands were dry. The policy indicated hand hygiene should be performed “after contact with a patient’s intact skin … when moving from a contaminated body site	G0682		

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G0682	Continued from page 27 to a clean body site during patient care … after removing gloves.” 3. Review of agency policy #7-010 titled “Clean Vs. Aseptic Technique,” revised 10/2019, indicated strategies for maintaining aseptic or sterile technique included but were not limited to establishing a sterile field. 4. Review of agency policy #7-012 titled Contaminated Materials Disposition, revised 10/2019, indicated all laboratory specimens should be kept in “an impermeable container with a biohazard label… to prevent leakage, should the collection container spill or break ….” 5. Review of agency policy #7-016 titled “Bag Technique,” revised 10/2019, indicated agency field staff using a supply bag should clean reusable equipment prior to returning the equipment to the supply bag. 6. Review of agency policy #N-9.14 titled “Peripherally Inserted Central Catheter (PICC) Maintenance and Management of Potential Complications, effective 05/01/2015, indicated when performing a PICC injection port, the skilled professional should wrap an alcohol wipe around the junction between the injection port and extension set “until injection port is removed.” 7. A home visit observation was conducted with Patient #1 on 06/20/2023 beginning at 9:38 AM. At the start of the visit, PT 1 was observed waving their hands to dry the hand sanitizer used to perform hand hygiene. After obtaining the patient’s vital signs, the therapist wiped their thermometer, blood pressure cuff, and oxygen saturation monitor using a Spa Room Sanitizing Alcohol Wipe, then piled the equipment on top of each other prior to the equipment drying. The therapist failed to perform hand hygiene after cleaning the equipment. After the equipment had dried, the therapist was observed failing to perform hand hygiene prior to entering their supply bag to return the vital sign equipment. While performing an assessment of the Patient #1’s right lower leg, which had a dressing over a wound, PT 1 touched the patient’s reddened skin above the wound dressing then used a dirty sanitizing wipe to perform hand hygiene. Throughout the visit, the therapist was observed failing to perform hand hygiene on 5 occasions after donning or removing their face mask. During an interview with PT 1 on 06/20/2023 beginning at 10:38 AM, the physical therapist indicated they should perform hand hygiene prior to entering their	G0682		

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G0682	Continued from page 28 supply bag. 8. A home visit observation was conducted with Patient #2 on 06/20/2023 beginning at 2:07 PM. During the visit, PTA 3 was observed obtaining the patient's vital signs using a thermometer, blood pressure cuff, and SpO2 monitor. At the end of the visit, PTA 3 was observed wiping the equipment using a Spa Room Sanitizing Alcohol Wipe then placing the equipment immediately back into their supply bag. The assistant failed to allow the equipment to dry after sanitizing and prior to returning to their bag. During an interview with PTA 3 on 06/20/2023 beginning at 2:51 PM, the therapy assistant reported they did not know the dry time for the alcohol sanitizer wipes used during the visit. PTA 3 reported they should "wait a few seconds" and ensure the equipment was not wet before returning to their supply bag. 9. A home visit observation was conducted with Patient #3 on 06/21/2023 beginning at 9:25 AM. During the visit, RN 1 was observed on 2 occasions failing to perform hand hygiene immediately after removing gloves. The nurse failed to change their gloves and perform hand hygiene when moving from dressing the patient's right heel wound to removing the old dressing on the patient's left heel wound. At the end of the visit, RN 1 wiped their stethoscope, thermometer, blood pressure cuff, SpO2 monitor, and bandage scissors with a Sani-Cloth alcohol wipe but failed to allow the equipment to dry prior to returning it to their supply bag. During an interview with RN 1 on 06/20/2023 beginning at 10:07 AM, the nurse reported they should perform hand hygiene when moving from one wound site to another. When queried on the dry time for the alcohol wipes RN 1 used to sanitize their equipment, the nurse stated it was 30 or 90 seconds. The nurse confirmed they should have waited for the equipment to dry prior to returning it to their supply bag. 10. A home visit observation was conducted with Patient #4 on 06/21/2023 beginning at 1:25 PM. During the visit, PT 2 was observed obtaining using a gait belt as a safety measure while the patient performed exercises. At the end of the visit, the therapist was observing wiping the gait belt with a Sani-Cloth alcohol wipe then placed the gait belt on top of a dirty SpO2 monitor. Review of Patient #5's clinical record included a plan of care for the initial certification period of	G0682		

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G0682	Continued from page 29 05/19/2023 – 07/17/2023 which indicated the patient's primary diagnosis was infection after joint replacement surgery. The plan of care indicated Patient #5 had a peripherally inserted central catheter (PICC, type of IV placed into vein in arm or neck, used for home IV medication and/or infusion administration) and was to receive Ceftriaxone (antibiotic) through the PICC line once a day. The plan of care indicated the patient was to receive skilled nursing visits once a week with nursing interventions to include but not limited to "change injection cap according to agency protocol … perform PICC line dressing change using sterile technique … draw labs [once a week] …." 11. A home visit observation was conducted with Patient #5 on 06/22/2023 beginning at 8:49 AM. During the visit, Patient #5 was observed to have a PICC line in their left upper arm. When starting the PICC dressing change procedure, RN 1 donned gloves, opened the sterile PICC dressing kit, gave Patient #5 a face mask and donned their own face mask, then failed to change gloves and perform hand hygiene prior to removing the patient's old PICC dressing. Later during the procedure, RN 1 was observed failing to maintain their sterile field by placing used supplies onto the sterile field next to sterile saline flushes prior to the flushes being used. The nurse obtained a blood sample from the PICC line in a syringe, transferred the blood into 2 laboratory tubes, placed the specimen tubes into a biohazard bag, then placed the bag into their scrub shirt pocket. During an interview with RN 1 conducted on 06/22/2023 beginning at 9:30 AM, the nurse reported the saline flushes used during the PICC dressing change were not considered sterile, therefore the sterile field was maintained despite the nurse placing used supplies next to the saline flushes. During a follow up interview with RN 1 conducted on 06/23/2023 beginning at 12:46 PM, the nurse confirmed Patient #5's laboratory specimen was not stored in a biohazard bin while the nurse transported the specimen to a laboratory. 12. During an interview with the Clinical Supervisor on 06/22/2023 beginning at 3:52 PM, the Clinical Supervisor reported staff should let hands "air dry" when performing hand hygiene with alcohol-based hand sanitizer and confirmed staff should perform hand hygiene before donning and after removing gloves, before entering their supply bag, after donning and removing mask, moving from performing care on one wound to a new wound. The Clinical Supervisor confirmed after	G0682		

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G0682	Continued from page 30 disinfecting used equipment with a sanitizing wipe, staff should allow the equipment to dry prior to returning it to their supply bag. The Clinical Supervisor also confirmed opened sterile equipment and supplies should be kept on a clean field or barrier when performing a sterile procedure. 410 IAC 17-12-1(m)	G0682		
G0700	Skilled professional services CFR(s): 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician or allowed practitioner and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care. This CONDITION is NOT MET as evidenced by: Based on observation, record review, and interview, the skilled professional failed to conduct a thorough and complete ongoing assessment (see Tag G706) and failed to provide services as ordered by the physician on the patient's plan of care (see Tag G710). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure provision of quality health care by its skilled professionals, which resulted in the agency being found out of compliance with Condition of Participation 484.75 Skilled professional services.	G0700		
G0706	Interdisciplinary assessment of the patient CFR(s): 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the skilled professional failed to conduct a thorough and complete ongoing assessment for 4 of 6 home visit observations with a skilled professional performing the visit (Patient #1, 3, 4, 5) and 4 of 4 records reviewed	G0706		

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G0706	Continued from page 31 of a patient with an active wound (Patients #1, 3, 8, 9). Findings include: 1. Review of agency policy #1-016 titled “Initial and Comprehensive Assessment,” revised 05/2022, indicated the comprehensive assessment should be “patient-specific and comprehensive” and should include “baseline data to be used in measuring the patient’s progress towards goals” as well as a physical assessment with “relevant data related to pertinent physical findings.” 2. Review of agency policy #1-021 titled “Pain Assessment,” revised 10/2019, indicated the clinician should be asked a “general screening question regarding current or recent pain as part of the baseline data” during the initial assessment. The policy indicated when a patient reported pain and/or the clinician identified pain, an in-depth pain assessment should be performed. The in-depth pain assessment included but was not limited to an assessment of the pain “intensity” using a rating scale (often a 0 -10 numeric scale where 0 meant no pain and 10 meant “unbearable” pain), including current pain intensity, worst pain intensity, and least pain intensity; pain location, quality, presence or absence of radiation, factors which make the pain better, factors which make the pain worse, present pain management regimen and effectiveness, effects of pain on aspects of daily life, and the patient’s pain goal(s). 3. Review of agency policy #1-024 titled “Discharge Criteria and Process,” revised 04/2021, indicated the discharge process should include “an update to the comprehensive assessment.” 4. Review of agency policy #1-025 titled “Discharge Summary,” revised 05/2022, indicated a discharge summary would be complete by a skilled professional for each discipline the patient received. The policy indicated the discharge summary should include but not limited to the patient’s “medical status at discharge including continuing symptom management needs” and “the overall status of the patient.” 5. Review of agency policy #N-7.01 titled “Pressure Ulcer – Prevention,” revised 05/01/2015, indicated the patient’s skin should be inspected at each visit as part of “general skin care and early treatment” of pressure ulcer wounds. 6. Review of agency policy #N-9.14 titled “Peripherally	G0706		

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G0706	Continued from page 32 Inserted Central Catheter (PICC) Maintenance and Management of Potential Complications, effective 05/01/2015, indicated when changing the PICC dressing, the skilled professional should “verify that external catheter length visible outside [of the body] corresponds to initial placement measurement. If it does not, notify physician before continuing use.” 7. Review of agency job description for the title of RN, revised 10/2019, indicated the nurse’s job functions and responsibilities included but were not limited to “regularly re-evaluates patient nursing needs.” 8. Review of the clinical record of Patient #1 included a plan of care for the initial certification period of 06/15/2023 – 08/13/2023 which indicated patient diagnoses included but were not limited to atrial fibrillation (an irregular heart rhythm) and patient medications included but were not limited to Cephalexin (an antibiotic) and Tylenol Extra Strength (an over-the-counter pain medication) as needed for pain. The plan of care indicated the patient was to receive skilled nursing and physical therapy services. The plan of care indicated skilled nursing interventions included but were not limited to assessing Patient #1’s right lower leg wound, including monitoring for evidence of infection and evaluating the site’s temperature and healing process, as well as assessing Patient #1’s pain. The plan of care indicated Patient #1’s functional limitations included but were not limited to pain. The record included an initial comprehensive assessment completed on 06/15/2023 by RN 1. The assessment summary indicated Patient #1 had a skin tear to the right lower leg and was taking an antibiotic for “possible cellulitis” (an infection of the outer skin layers). The assessment failed to evidence an assessment of Patient #1’s right lower leg wound for wound bed appearance, surrounding skin color, and presence or absence of odor and/or heat at the site. The assessment also failed to evidence a complete pain assessment, including location and frequency of pain, what makes the pain better or worse, current pain relief measures, whether pain relief measures are adequate, and how the pain interferes or impacts the patient’s functional/activity level. A home visit observation was conducted with Patient #1 on 06/20/2023 beginning at 9:38 AM. During the visit, Patient #1’s right lower leg was noted to have redness directly above the wound dressing. PT 1 indicated they had observed this redness during their initial visit	G0706		

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G0706	Continued from page 33 with Patient #1 on 06/16/2023. Patient #1 was observed taking a dose of Tylenol Extra Strength during the visit due to pain in their right leg. During the visit, PT 1 failed to listen to all lung fields, by failed to obtain the patient's heart rate by listening to the patient's rate for 60 seconds, and failed to assess for any new medications or medication changes. During an interview with PT 1 conducted on 06/20/2023 beginning at 10:38 AM (after the visit with Patient #1 had completed), the therapist confirmed they assessed the patient's lung sounds in only 3 of the 5 lung lobes, obtained the patient's heart rate by listening to the heart for only 6 seconds, and failed to ask the patient if there were any medications or medication changes. During an interview with Patient #1 conducted on 06/20/2023 beginning at 10:46 AM, the patient reported they had completed their prescription of Cephalexin and was no longer taking the medication. 9. Review of Patient #3's clinical record (start of care 03/30/2022) indicated the patient had a primary diagnosis of a Stage II pressure ulcer (type of pressure ulcer wound where the wound has gone below the outer skin layers) to the right heel and secondary diagnoses including but not limited to Stage II pressure ulcer to the left heel, Stage II pressure ulcer to the left buttocks, and paraplegia (inability to move the lower part of body). The plan of care indicated the patient was to receive skilled nursing services for 1 visit per week with nursing interventions including but not limited to assessing for any skin alterations and wounds, monitoring any wounds for evidence of infection, evaluating wound healing process, assessing for verbal and nonverbal signs of pain, and conducting a lung sound assessment. The record indicated a skilled nursing visit was conducted on 06/14/2023. The visit note failed to evidence the nurse assessed Patient #3's wounds' bed appearance, presence or absence of odor, nor surrounding skin appearance. A home visit observation was conducted with Patient #3 on 06/21/2023 beginning at 9:25 AM. During the visit, RN 1 failed to listen to all of the patient's lung fields, failed to listen for bowel sounds despite the patient reporting only having one bowel movement in the past 10 days and having one episode of emesis on 06/20/2023, and failed to conduct a complete skin assessment. During the visit, Patient #3 reported pain to their right lower abdomen however RN 1 failed to conduct a pain assessment including the pain	G0706		

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G0706	Continued from page 34 description, severity, etc. The nurse also failed to assess for any new medications or medication changes. 10. A home visit observation was conducted with Patient #4 on 06/21/2023 beginning at 1:25 PM. During the visit, PT 2 was observed performing a discharge assessment of the patient. The therapist failed to listen to the patient's lung sounds, heart tones, and bowel sounds. During an interview with PT 2 conducted on 06/21/2023 beginning at 2:15 PM, the physical therapist confirmed they did not routinely assess a patient's lung sounds or other body systems during a discharge assessment, and would only conduct an assessment if they felt there was a need. 11. Review of Patient #5's clinical record included a plan of care for the initial certification period of 05/19/2023 – 07/17/2023 which indicated the patient's primary diagnosis was infection after joint replacement surgery. The plan of care indicated Patient #5 had a peripherally inserted central catheter (PICC, type of IV placed into vein in arm or neck, used for home IV medication and/or infusion administration) and was to receive Ceftriaxone (antibiotic) through the PICC line once a day. The plan of care indicated the patient was to receive skilled nursing visits once a week with nursing interventions to include but not limited to "change injection cap according to agency protocol … perform PICC line dressing change using sterile technique … draw labs [once a week] …." A home visit observation was conducted with Patient #5 on 06/22/2023 beginning at 8:49 AM. During the visit, Patient #5 was observed to have a PICC line in their left upper arm and RN 1 changed the PICC dressing. The nurse failed to assess the external length of the PICC nor left arm circumference during the visit. During an interview with RN 1 conducted on 06/22/2023 beginning at 9:30 AM, the nurse confirmed they did not assess the external length of the PICC nor the patient's left arm circumference. RN 1 reported they did not routinely assess the external length of a PICC unless there is a physician order to do so. 12. Review of Patient #8's clinical record included a plan of care for the initial certification period of 06/08/2023 – 08/06/202 which indicated the patient's diagnoses included but were not limited to Stage 2 pressure ulcer on left buttock. The plan of care indicated the patient was to receive skilled nursing services for 1 visit per week for 4 weeks and skilled	G0706		

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G0706	Continued from page 35 nursing interventions included but were not limited to assessing for any skin alterations and/or wounds, monitoring for evidence of infection, evaluating the wound's healing process, and performing wound care to the site. The record included an initial comprehensive assessment completed on 06/08/2023 and skilled nurse visit completed on 06/22/2023, both documented by RN 1. The visit notes failed to evidence the nurse assessed the patient's buttock's wound for wound bed appearance, surrounding skin appearance, the presence or absence of wound odor, or for other signs and symptoms of wound infection. 13. Review of Patient #9's clinical record included a plan of care for the initial certification period of 05/10/2023 – 07/08/2023 which indicated patient diagnoses included but were not limited to non-pressure chronic ulcers of the right and left foot. The plan of care indicated the patient was to receive skilled nursing services for 2 visits per week for 9 weeks and skilled nursing interventions included but were not limited to assessing for any skin alterations and/or wounds, monitoring for evidence of infection, evaluating the wound's healing process, and performing wound care to the sites. The record included an initial comprehensive assessment completed on 05/10/2023, skilled nursing visits conducted on 05/12/2023, 05/19/2023, 06/02/2023, 06/07/2023, 06/09/2023, 06/16/2023, 06/21/2023, 06/23/2023, and a resumption of care comprehensive assessment completed on 05/25/2023, all documented by RN 1. The visit notes failed to evidence the nurse assessed the patient's foot wounds for wound bed appearance, surrounding skin appearance, the presence or absence of wound odor, or for other signs and symptoms of wound infection. The visit note documented on 05/19/2023 indicated the patient had a large amount of drainage from their left foot wound but failed to evidence the color and consistency of the drainage. 14. During an interview with the Clinical Supervisor conducted on 06/22/2023 beginning at 3:52 PM, the Clinical Supervisor reported the skilled professional should assess lung sounds by listening to breath sounds in all lung fields, the skilled professional should assess for any new or changed medications at each visit, and a complete physical assessment, including heart tones, lung sounds, and bowel sounds, should be assessed by the skilled professional during a discharge assessment. The Clinical Supervisor confirmed for patients with a history of an irregular heart rhythm, the skilled professional should obtain the patient's heart rate by either auscultating (listening with a stethoscope) or palpating (assessing by touch) the	G0706		

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G0706	Continued from page 36 patient's heart rate for 1 minute. The Clinical Supervisor reported the skilled professional should assess the patient's gastrointestinal system should include listening for bowel sounds in all 4 abdominal quadrants, a pain assessment should include location, severity, type, frequency, and what makes the pain better and worse. The Clinical Supervisor confirmed at every visit the skilled professional should perform a complete skin assessment on a patient with a high risk of pressure ulcers and the PICC line assessment should include verifying external measurement and presence or absence of blood return. During an interview with the Clinical Supervisor conducted on 06/26/2023 beginning at 4:27 PM, the Clinical Supervisor reported the skilled professional's assessment and documentation for all wounds should include but not be limited to wound bed appearance, surrounding skin appearance, and presence or absence of signs or symptoms of infection, including odor.	G0706		
G0710	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the skilled professional failed to provide services as ordered by the physician on the patient's plan of care for 2 of 7 home visit observations of a skilled professional visit with 2 of 6 patients (Patients #5, 22). 1. Review of agency policy #N-9.14 titled "Peripherally Inserted Central Catheter (PICC, a type of IV placed into vein in arm or neck, used for home IV medication and/or infusion administration) Maintenance and Management of Potential Complications, effective 05/01/2015, indicated when drawing blood from a PICC, the skilled professional should aspirate for blood return prior to injecting saline "to determine PICC patency." 2. Review of an agency job description for the role of Physical Therapist (PT), last revised 10/2019, indicated the therapist's job duties included providing therapy services to patients according to the plan of care. 3. Review of Patient #5's clinical record included a	G0710		

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G0710	Continued from page 37 plan of care for the initial certification period of 05/19/2023 – 07/17/2023. The plan of care indicated Patient #5 had a PICC line, was to receive skilled nursing services, and nursing interventions to be provided included but were not limited to drawing blood from the PICC line weekly for laboratory (lab) work. A home visit observation was conducted with Patient #5 on 06/22/2023 beginning at 8:49 AM. During the visit, RN 1 was observed obtaining a blood sample for lab work from the patient's left upper arm PICC line. When performing the procedure, the nurse failed to aspirate for blood return prior to injecting saline. During an interview conducted with RN 1 on 06/22/2023 beginning at 9:30 AM, the nurse confirmed when obtaining Patient #5's blood sample from their PICC line, the nurse did not aspirate for blood return prior to flushing the line. 4. Review of Patient #22's clinical record included a plan of care for the initial certification period of 05/05/2023 - 07/03/2023 which indicated the frequency of PT visits were one time a week for the last week of the certification period. Review of PT visits completed during the certification period 05/05/2023 - 07/03/2023 failed to evidence a PT visit was conducted during the last week of the certification period (week that began on 07/02/2023). The record included a plan of care for the recertification period 07/04/2023 - 09/01/2023 which indicated the patient diagnosis included but not limited to left foot drop (difficulty lifting front of foot) and history of falling. The plan of care indicated PT interventions included but were not limited to working with Patient #22 in balance safety, gait/ambulation (walking), and transfer training (moving body from one surface to another). During a home visit conducted on 07/10/2023 at 10:15 AM with Patient #22, the patient asked PT 1 if walking exercises would be completed during the visit. PT 1 responded "not today." The PT failed to follow all therapy interventions according to the plan of care. During an interview conducted with PT 1 on 07/10/2023 beginning at 3:30 PM, the therapist reported walking and balance were underlying deficits of Patient #22. The therapist reported interventions for balance and walking would be performed with Patient #22 as needed. 410 IAC 17-14-1(a)(1)(H)	G0710		

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G0710 G0944	Administrator must: CFR(s): 484.105(b)(1) Standard: Administrator. The administrator must: This STANDARD is NOT MET as evidenced by: Based on record review and interview, the administrator failed to perform all required functions specific to ensuring all home health aides (HHA) had completed mandatory training and were up-to-date on their state certification for 2 of 2 home health aide personnel files reviewed (HHA 1, HHA 2). Findings include: 1. Review of an agency job description for the position of administrator, revised 10/2019, indicated the administrator's job functions and responsibilities included but were not limited to "complying with applicable law and regulation … retaining qualified personnel … ensuring staff development including … in service education [and] continuing education …." 2. Review of an agency job description for the position of Certified Home Health Aide, revised 10/2019, indicated the home health aide should maintain good standing on the state nurse aide registry. 3. Title 42 of the Code of Federal Regulations 484.80(d), last revised 02/21/2020, indicated all home health aides must complete a minimum of 12 hours of in-service training annually. 4. Indiana Code IC 16-27-1.5-5, effective 07/01/2022, indicated all home health aides who provided care to at minimum one patient with dementia or similar cognitive disorders must complete at least 6 hours of approved dementia training upon hire and at least 3 hours annually. 5. Review of Home Health Aide 1's personnel file failed to evidence the employee completed at least 6 hours of approved dementia training and 12 hours of annual in-service training in 2022. The personnel file also failed to evidence the aide held a current home health aide certification through the state of Indiana. A search on Indiana's Professional License website, www.mylicense.in.gov, evidenced Home Health Aide 1's certification as a home health aide through the state	G0710 G0944		

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G0944	Continued from page 39 of Indiana expired on 06/02/2023. During an interview with the Administrator on 06/27/2023 beginning at 11:33 AM, the Administrator confirmed Home Health Aide 1's certification for home health aide through the state of Indiana was expired. 6. Review of Home Health Aide #2's personnel file failed to evidence the employee completed at least 6 hours of approved dementia training and 12 hours of annual in-service training in 2022. 7. On 6/27/23 at 11 AM, the administrator indicated their home health aides had not completed their minimum required education and or training.	G0944		