STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157553	A. BUILDING B. WING	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HOMECARE NETWORK	1400 E MCGALLIARD RD, MUNCIE, IN, 47303

(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 State Department of Health in accordance with 42 CFR 484.102. Survey Dates: January 22, 23, 24, and 25; 2024 Facility Number: 003788 Census: 125 At this Emergency Preparedness survey, Indiana Homecare Network was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR Completed on 01/30/2024 by A4	E0000		

G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure survey of a Home Health Provider. Survey Dates: January 22, 23, 24, 25, 2024 Facility ID: 003788 12-Month Unduplicated Skilled Admissions: 383 The survey was announced as partially extended on 1/24/2024 at 3:25 PM. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.	G0000		
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care;	G0434	Occurrence report entered for patient # 2 due toinaccurate referral documentation entered into medical record and patient # 5for failure to complete Occupational Therapy (OT) and Medical Social Worker (MSW)evaluations per policy. OT evaluation was not ordered on patient # 2 and	2024-02-16

	(iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview, the home health agency failed to ensure patients were informed of a delay in start of therapy services for 2 of 2 records which evidenced a lapse in time for therapy service(s) initiation (Patient #2 and 5). Findings Include: 1. A review of agency policy "Patient Rights and Responsibilities" indicated the patient has the right to participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to the care being furnished based upon the comprehensive assessment, the disciplines that will furnish care, the frequency of the visits and any changes in the care to be furnished. 2. The review of Patient #2's		waserroneously documented in the referral documentation within the electronicmedical record. OT and MSW evaluations not completed on patient # 5due to patient transferring to hospital. Need for OT and MSW will bere-assessed upon resumption of care. Physician notified via Transfer Summary. During a staff meeting held on 1/31/2024, theExecutive Director (ED) reviewed findings with the clinical and intake staffand instructed on policy 2.1.001 Admission Process and 2.1.002 PatientAssessment, Initial and Reassessment; and Clinical Comment Intake CoordinationNote Tip Sheet with emphasis on accuracy of referral information entered intothe electronic medical record and timely initiation of services. Forany staff unable to attend the staff meeting, the ED will	

	clinical record included a plan of care for the initial certification period 1/13/24 to 3/12/24. The plan of care indicated the patient was to receive an Occupational Therapy (OT) evaluation for services the week of 1/14/24. The record included an initial comprehensive assessment, conducted by Physical Therapist (PT) 3 on 1/13/24, which indicated Patient #2's need for OT services. The record failed to include an OT evaluation visit has been performed and failed to evidence communication with the patient regarding the delay in the OT evaluation. During a home visit on 1/23/24 beginning at 9:00 AM, Patient #2 stated they had not been contacted by the home health agency to have the OT evaluation scheduled and they have not received any OT services. During an interview on 1/24/23 beginning at 11:10 AM, the Administrator confirmed the OT evaluation visit had not been performed with Patient #2 and the clinical record failed to evidence documentation the patient had been notified of the		2/16/24. The Clinical Comment Intake Coordination Note iscompleted upon receipt of a referral at Start of Care (SOC) or Resumption ofCare (ROC). The Clinical Comment Intake Note contains referral orders andordered disciplines. The referral will be approved only after the ED orPatient Care Manager review all components of the referral, including theClinical Comment Intake Coordination Note to ensure it is accurate. During the admission/initial visit, the qualifiedclinician informs the patient/caregiver of anticipated services and frequency. Initial discipline specific evaluation(s) will occurwithin 5 days from the Start of care (SOC) date or order date or sooner ifmedically necessary.	

	delay. 3. The review of Patient #5's clinical record included a plan of care for the initial certification period from 1/11/24 to 3/10/24. The plan of care indicated the patient was to receive an Occupational Therapy (OT) and Social Work (SW) evaluation for services the week of 1/14/24. The record included an initial comprehensive assessment, conducted by Registered Nurse (RN) 4 on 1/11/24, which indicated Patient #5's need for OT and SW services. The record failed to include OT or SW evaluation visits and failed to evidence communication with the patient regarding the delay in the OT and SW evaluations. During an interview on 1/24/23 beginning at 11:10 AM, the Administrator confirmed the OT and SW evaluation visits had not been performed with Patient #5 and the clinical record failed to evidence documentation the patient has been notified of the delay. 410 IAC 17-12-3(b)(2)(D)(ii)(BB)		In event of a delayin the initiation of an ordered service, the patient/caregiver and physicianwill be notified. The person ultimately responsible for implementing the plan ofcorrection is the Executive Director. Beginning the week of 2/18/24 the ED will review 50% Startof Cares (SOC) for the prior week to ensure that the Clinical Comment IntakeCoordination Note is accurate and initiation of all ordered services was completedper policy. Monitoring willcontinue for 12 weeks and until 100% compliant for 8 consecutive weeks.	

G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the home health agency failed to ensure an initial assessment was completed by a registered nurse (RN) within 48 hours of referral for 1 of 3 active patients reviewed with SOC in the last 4 weeks (Patient #3). Findings Include: 1. A review of agency policy "Admission Process" indicated admission / initial visits are made within 48 hours from referral unless there is a specific physician ordered start of care (SOC) date which would supersede the state established timeframes. 2. The review of Patient #3's clinical record evidenced a referral for home health services	G0514	During a staff meeting held on 1/31/2024, theExecutive Director (ED) reviewed findings with clinical and intake staff and educatedon the Clinical Comment Intake Coordination Note Tip Sheet, Capturing Data fora Valid Home Health Referral, policy 2.1.001 Admission Process, and OASISProcess Measures: Timely Initiation of Care Tip Sheet with an emphasis on contentof valid referral accurate Clinical Comment Intake Coordination Note; and completionof the initial assessment within 48 hours of referral unless there is aspecific physician ordered start of care (POSOC) date. For any staff unable to attend the staff meeting, theED will provide 1:1 instruction by 2/16/24. A valid referral contains a physician/authorizedpractitioner's home health referral order that includes the patient's relevantdiagnosis and general home health needs and a confirmed, physician/authorizedpractitione	2024-02-16

	indicating Patient #3 would be discharged from Skilled Nursing Facility (SNF) on 12/23/23. The initial assessment by the Registered Nurse (RN) 3 was performed on 12/28/23. The clinical record failed to evidence documentation the physician was contacted regarding the delay in the initial assessment and failed to include a physician order to perform the initial assessment greater than 48 hours after the Patient #3 discharged from the SNF. 3. During an interview on 1/24/24 beginning at 11:10 AM, the Administrator confirmed the clinical record for Patient #3 did not include a physician's order for the delay in the initial assessment and confirmed the initial assessment was performed 5 days after Patient #3 was discharged from the SNF. 410 IAC 17-14-1(a)(1)(A)		r who will assume care of the patient during the home healthepisode. The Clinical Comment Intake Coordination Note will beutilized to document the date of the inquiry, date physician/authorizedpractitione r agreed to assume care, orders for initial care, and updatedreferral date. Admission/initialvisits are made within 48 hours from a valid referral unless there is aspecific POSOC date. The person ultimately responsible for implementing the plan ofcorrection is the Executive Director. Beginning the week of 2/18/24, the ED will review 50%of the prior weeks SOC assessments to ensure the Clinical Comment IntakeCoordination note was completed accurately, and initial assessment was completed within 48 hours of referral or on thePOSOC date.	

			Monitoring willcontinue for 12 weeks and until 100% compliant for 8 consecutive weeks.	
G0572	Plan of care 484.60(a)(1) 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. Based on record review and interview, the home health agency failed to review the plan of care (POC) with the attending physician for 1 of 2 active clinical records with an occupational therapist OT Evaluation in the last month (Patient #3) and 1 of 2 active clinical records reviewed with a registered nurse (RN) recertification in the last 6 weeks (Patient #6). Findings Include: 1. A review of agency policy" Plan of Care (POC)" indicated	G0572	Verbalorders obtained for Occupational Therapy (OT) plan of care on patient # 3. Signedphysician orders received on patient # 5. Duringa staff meeting held on 1/31/2024, the Executive Director (ED) reviewedfindings with clinical staff and educated on policy 2.1.007 Plan of Care, HomeHealth Start of Care Tip Sheet for Nursing, and Home Health Start of Care TipSheet for Therapy with emphasis on obtaining and documenting physician orallowed practitioner approval of the POC prior to providing further services. Forany staff unable to attend the staff meeting, the ED will provide 1:1instruction by 2/16/24. The qualified clinician develops	2024-02-16

	individualized POC developed in consultation with the patient, physician or authorized practitioner, and staff. The POC is established prior to providing services. 2. A review of agency policy "Physician Orders" included but not limited to, "The Plan of Care (POC), telephone and or verbal orders must be signed and dated...within a timely manner per state regulation...Indiana...30 days...Verbal or telephone orders are entered into the software system when received and include the time and date the verbal order was received, ordering physician/authorized practitioner, name of physician designee when applicable, clinician that relayed the order (if appropriate), and the clinician accepting the order. 3. The review of Patient #3's clinical record evidenced an OT evaluation completed on 12/30/23 by OT 1. The OT evaluation note indicated the physician would be notified via fax on 1/01/24 through the use of the MD/SBAR communication note. The clinical record failed to evidence		the POC under the directionof the physician or authorized practitioner. The POC is established andapproved prior to providing services. Clinicians willdocument communication with the physician/authorized practitioner, including approvaland receipt of verbal orders for the POC in the Care Coordination section ofthe assessment. The person ultimately responsible for implementing the plan ofcorrection is the Executive Director. Beginning the week of 2/18/24, the ED will review 10SOC, Resumption of Care (ROC), recertification, or add-on evaluations from theprior week to ensure the POC was approved prior to providing services. Monitoring willcontinue for 12 weeks and until 100% compliant for 8 consecutive weeks.	

verbal orders were obtained by OT 1 for the POC and failed to evidence the MD/SBAR communication note had been faxed to the physician.

During an interview on 1/24/24 beginning at 11:10 AM, the Administrator confirmed the clinical record for Patient #3 failed to include verbal or signed orders for the OT POC.

4. The review of Patient #6's clinical record evidenced a comprehensive reassessment visit completed on 12/12/23 by RN 3. The comprehensive assessment note failed to include documentation of collaboration with the attending nurse practitioner for the recertification POC.

During an interview on 1/24/24 beginning at 10:31 AM, RN 3 indicated they were unsure if they contacted the attending practitioner for recertification orders and they confirmed the clinical record for Patient #6 does not include any collaboration documentation with the physician.

During an interview on 1/24/24 beginning at 1:05 PM, the Administrator confirmed the

	clinical record for Patient #6 failed to include documentation the patient POC was reviewed with the attending practitioner. 410 IAC 17-13-1(a)(2)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (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;	G0574	Patients#1, #4, and #6 Plan of Care (POC) was updated with appropriate safety measures. Duringa staff meeting held on 1/31/2024, the Executive Director (ED) reviewedfindings with clinical staff and educated on policy 2.1.007 Plan of Care withemphasis on ensuring the safety measures include all safety measures to protectthe patient from harm, including bleeding and diabetic precautions. Forany staff unable to attend the staff meeting, the ED will provide 1:1instruction by 2/16/24.	2024-02-16

	(xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the home health agency failed to ensure the plan of care included all safety measures to protect against injury for 3 of 7 active records reviewed (Patients #1, 4 and 6). Findings Include: 1. A review of agency policy" Plan of Care (POC)" indicated each patient has an individualized POC developed in consultation with the patient, physician or authorized practitioner, and staff. The POC is updated no less than every 60 days and includes safety measures to protect against injury. 4. The review of Patient #6's clinical record included a POC for certification period 12/13/23 to 2/10/24 and a medication list which included Levemir (insulin medication used to treat diabetes), Metformin (medication used to help control the amount of glucose (sugar) in your blood) and Novolog (medication used at mealtimes to help control blood		Each patient has an individualized Plan of Care (POC)developed in consultation with the patient, physician or authorizedpractitioner. The POC includes safety measures to protect againstinjury, including bleeding precautions for those patients prescribed antiplateletor anticoagulants, and diabetic precautions for those with diabetic diagnosis. The Patient Care Manager (PCM) will review the POC toensure the POC contains the proper safety measures/ The person ultimately responsible for implementing the plan ofcorrection is the Executive Director. Beginning the week of 2/18/24, the ED will review 10POC per week to ensure the safety measures are accurate.	

	sugar spikes) and included a diagnosis of Type 2 Diabetes Mellitus. The POC failed to include diabetic precautions as a safety measure. During an interview on 1/24/24 beginning at 11:10 AM, the Administrator confirmed the POC for Patient #6 did not include the diabetic precautions safety measure and confirmed Patient #6 was taking diabetic medications and the home health agency was providing diabetic foot care. 410 IAC 17-13-1(a)(1)(C)(x) 2. Patient #1's clinical record included a plan of care (POC) for certification period 12/22/23 to 02/19/23. The POC included Aspirin children's 81 milligram (mg) chewable tablet (an antiplatelet medication used to reduce the risk of a heart attack or stroke) to be taken once daily and included a diagnosis of Type 2 Diabetes Mellitus with diabetic chronic kidney disease. The POC failed to include bleeding precautions and diabetic precautions. On 01/24/24 at 3:30 PM, the Administrator relayed they would expect to see bleeding		Monitoring willcontinue for 12 weeks and until 100% compliant for 8 consecutive weeks.	

	precautions in the POC if the patient was on an antiplatelet medication and would expect to see diabetic precautions in the POC if the patient had a diabetes diagnosis. The Administrator indicated Patient #1's medication list included Aspirin and the POC diagnosis list included diabetes. The Administrator relayed Patient #1's POC did not include bleeding precautions or diabetic precautions. 3. Patient #4's clinical record included a plan of care (POC) for certification period 12/24/23 to 02/21/23. The POC included Eliquis 5 mg tablet (an anticoagulant medication used to reduce the risk of blood clots) to be taken twice daily and included a diagnosis of Type 2 Diabetes Mellitus with foot ulcer. The POC failed to include bleeding precautions and diabetic precautions. On 01/24/24 at 3:30 PM, the Administrator relayed they would expect to see bleeding precautions in the POC if the patient was on an anticoagulant medication and would expect to see diabetic precautions in the			

	diabetes diagnosis. The Administrator indicated Patient #4's medication list included Eliquis and the POC diagnosis list included diabetes. The Administrator relayed Patient #4's POC did not include bleeding precautions or diabetic precautions.			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the home health agency failed to ensure frequency orders were received and recorded prior to staff providing services for 5 of 7 active records reviewed (Patients #2, 3, 5, 6 and 7). Findings Include: 1. A review of agency policy "Physician Orders" included but not limited to, "The Plan of Care (POC), telephone and or verbal orders must be signed and dated...within a timely manner per state	G0580	Occurrencereport was entered for patient #2, 3, 5, 6, and 7 for failure to obtainapproval of frequency of visits prior to providing services. Verbalorders obtained for plan of care and sent to physician on patient # 3. Signedphysician orders received on patient # 2, 5, 6, and 7. Duringa staff meeting held on 1/31/2024, the Executive Director (ED) reviewedfindings with clinical staff and educated on policy 2.1.007 Plan of Care, HomeHealth Start of Care Tip Sheet for Nursing, and Home Health Start of Care TipSheet	2024-02-16

	days...Verbal or telephone orders are entered into the software system when received and include the time and date the verbal order was received, ordering physician/authorized practitioner, name of physician designee when applicable, clinician that relayed the order (if appropriate), and the clinician accepting the order. 2. The review of Patient #2's clinical record included a start of care (SOC) on 1/13/24 and a POC for certification period 1/13/24 to 3/12/24 with orders for Physical Therapy (PT) service frequencies of 1 visit a week for 1 week; 2 visits a week for 3 weeks then 1 visit a week for 3 weeks. The record evidenced PT visits were performed on 1/16/24, 1/18/24 and 1/23/24. The record failed to evidence documentation of a verbal order or a signed written order for the POC frequencies was obtained prior to the above visits performed. During an interview on 1/23/24 beginning at 2:05 PM, PT 1 confirmed they did not collaborate with the physician regarding the POC on 1/13/24 during their initial assessment		for Therapy with emphasis on obtaining and documenting physician orallowed practitioner approval of the POC, including visit frequency, prior toproviding further services. Forany staff unable to attend the staff meeting, the ED will provide 1:1instruction by 2/16/24. The qualified clinician develops the POC under thedirection of the physician or authorized practitioner. The POC is established andapproved prior to providing services. Clinicians willdocument communication with the physician/authorized practitioner, including approvaland receipt of verbal orders for the POC, including frequency, in the CareCoordination section of the assessment. The person ultimately responsible for implementing the plan ofcorrection is the Executive Director.	

	of Patient #2. During an interview on interview on 1/24/24 beginning at 11:10 AM, the Administrator confirmed the clinical record for Patient #2 failed to include documentation of a verbal order or signed written orders for Patient #2's POC frequencies. 3. The review of Patient #3's clinical record included a start of care (SOC) on 12/28/23, an OT evaluation on 12/30/23 and a POC for certification period 12/28/23 to 2/25/24 with orders for Occupational Therapy (OT) service frequencies of 1 visit a week for 1 week; 2 visits a week for 3 weeks then 1 visit a week for 4 weeks. The record evidenced OT visits were performed on 1/04/24, 1/05/24, 1/09/24, 1/11/24, 1/16/24, 1/17/24 and 1/23/24. The record failed to evidence documentation of a verbal order or a signed written order for OT service frequencies was obtained prior to the above visits performed. During an interview on interview on 1/24/24 beginning at 11:10 AM, the Administrator		Beginning the week of 2/18/24, the ED will review 10SOC, Resumption of Care (ROC), recertification, or add-on evaluations from theprior week to ensure the POC, including frequency, was approved prior toproviding services. Monitoring willcontinue for 12 weeks and until 100% compliant for 8 consecutive weeks.	

	confirmed the clinical record for Patient #3 failed to include documentation of a verbal order or signed written orders for Patient #3's OT POC frequencies. 4. The review of Patient #5's clinical record included a start of care (SOC) on 1/11/24 and a POC for certification period 1/11/24 to 3/10/24 with orders for Skilled Nurse (SN) service frequencies of 1 visit a week for 1 week; 2 visits a week for 2 weeks then 1 visit a week for 6 weeks. The record evidenced a SN visit was performed on 1/17/24. The record failed to evidence documentation of a verbal order or a signed written order for the POC frequencies was obtained prior to the above visit being performed. During an interview on interview on 1/24/24 beginning at 11:10 AM, the Administrator confirmed the clinical record for Patient #5 failed to include documentation of a verbal order or signed written orders for Patient #5's POC frequencies. 410 IAC 17-13-1(a)(1)(iii) 5. Patient #7's clinical record			

	contained a written add on discipline order dated 12/07/23 for occupational therapy (OT) effective 12/04/23 for 1 time per week for 1 week, 2 times per week for 3 weeks, and 1 time per week for 3 weeks. The written order indicated there was no verbal order received for the OT services and that the physician-signed, written order was received by the agency on 01/02/24. The clinical record included an occupational therapy assistant (COTA) note for a visit on 12/18/23 in which COTA 1 performed OT services for Patient #7. Patient #7's clinical record failed to evidence the agency had an order to perform OT services for Patient #7 on 12/18/23. On 01/25/24 at 2:27 PM, the Administrator relayed there was no verbal order for OT services for Patient #7 beyond the OT evaluation visit on 12/07/23. The Administrator indicated the physician-signed, written order for OT services effective 12/04/23 was received by the agency on 01/2/24. The Administrator relayed there was			

	occurred prior to the order being received by the agency.			
G0584	Verbal orders 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. Based on record review and interview, the home health agency failed to ensure all verbal orders were entered into the electronic medical record and sent to the physician / attending practitioner for signature for 4 of 7 active records reviewed (Patients #2, 3, 5 and 6). Findings Include: 1. A review of agency policy “Physician Orders” indicated	G0584	Physicianorders sent to physician for patients # 2,3,5, and 6. Duringa staff meeting held on 1/31/2024, the Executive Director (ED) reviewedfindings with clinical staff and educated on policy 2.1.008 Physician Ordersand Verbal Orders Job Aid with emphasis on entering verbal orders into theelectronic medical record and sent to the physician/attending practitioner forsignature; and include the verbal order path. Forany staff unable to attend the staff meeting, the ED will provide 1:1instruction by 2/16/24. All verbal orders must be reduced to writing andsigned/dated by the ordering physician. The Plan of Care (POC),	2024-02-16

	entered into the software system when received and include the time and date the verbal order was received, ordering physician/authorized practitioner, name of physician designee when applicable, clinician that relayed the order (if appropriate), and the clinician accepting the order. 2. The review of Patient #2's clinical record included a comprehensive assessment performed on 1/13/24 by Physical Therapist (PT) 1 and a communication note dated 1/15/24, which stated Other Person B gave a verbal order stating the POC was approved by Physician A. The clinical record failed to evidence a written verbal order was generated and sent to Physician A for signature. During an interview on 1/23/24 beginning at 2:05 PM, PT 1 confirmed they did not create a verbal order for Patient #2's plan of care to be sent to Physician A for signature. 3. The review of Patient #3's clinical record included a comprehensive assessment performed on 12/28/23 by		telephone and or verbal ordersmust be signed and dated by the physician or authorized practitioner within 30days. The order must include the date and time the order wasreceived; be written exactly as given by the physician or physician's representative;and include a verbal order path (for example VO Doctors name/physician designee(if applicable)/name of person with title receiving the order). The person ultimately responsible for implementing the plan ofcorrection is the Executive Director. Beginning 2/18/24, the ED will review 10 medicalrecords per month to ensure physician orders have been entered in theelectronic medical record, include the verbal order path, as indicated, andhave been sent to the physician for signature. Monitoring will continue for 3 months and until 100%compliant for 2	

	Registered Nurse (RN) 3 and a QR communication note dated 1/02/24, which stated RN 3 spoke with Other Person D at Physician C's office stating Physician C agrees with all recommendations in the POC. The clinical record failed to evidence a written verbal order was generated and sent to Physician C for signature. During an interview on 1/24/24 beginning at 11:10 AM, the Administrator confirmed the clinical record for Patient #3 failed to include complete verbal order documentation and indicated a verbal order had not been generated or sent to the physician for signature. 4. The review of Patient #5's clinical record included a comprehensive assessment performed on 1/11/24 by Registered Nurse (RN) 4 and a QR communication note dated 1/17/24, which stated RN 4 spoke with Other Person F at Physician's office E on 1/12/23 at 9:00 AM and RN 4 agrees with all recommendations in the QR POC recommendations note dated 1/16/23. The clinical record failed to evidence a written verbal order was		consecutive months.	

	received and sent to Physician E for signature. During an interview on 1/24/24 beginning at 2:16 PM, RN 4 stated they were unsure if they contacted Physician E for the recertification POC. During an interview on 1/24/24 beginning at 11:10 AM, the Administrator confirmed the clinical record for Patient #5 failed to include verbal order documentation and indicated a verbal order had not been generated or sent to the physician for signature. 5. The review of Patient #6's clinical record included a recertification comprehensive assessment performed on 12/12/23 by Registered Nurse (RN) 3 and a QR communication note dated 12/19/23, which stated RN 3 spoke with Attending Practitioner G 12/12/23 at 4:00 PM and RN 4 agrees with all recommendations in the QR POC recommendations note dated 12/15/23. The clinical record failed to evidence a written verbal order was received and sent to Attending Practitioner G for signature.			

	During an interview on 1/24/24 beginning at 9:59 AM, RN 3 stated they were unsure if they contacted Attending Practitioner G for the recertification POC and confirmed they did not create a verbal order for Patient #6's plan of care to be sent to Attending Practitioner G for signature. During an interview on 1/24/24 beginning at 11:10 AM, the Administrator confirmed the clinical record for Patient #6 failed to include complete verbal order documentation and indicated a verbal order had not been generated or sent to the physician for signature. 410 IAC 17-14-1(a)(1)(H)			
G0598	Discharge plans communication 484.60(c)(3)(ii) (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any).	G0598	Occurrencereport entered for patient # 3 for failure to notify physician of discharge. Duringa staff meeting held on 1/31/20204, the Executive Director (ED) reviewedfindings with clinical staff and educated on policy 2.1.004 PatientDischarge/Transfer Process and 2.1.017	2024-02-16

	Based on record review and interview, the home health agency failed to document collaboration with the physician prior to discharge from physical therapy (PT) services for 1 of 1 active patient records reviewed with a PT discharge (Patient #3). Findings Include: 1. A review of agency policy "Patient Discharge / Transfer Process" indicated revisions to plan for patient's discharge will be communicated to the patient, patient's representative if any, caregiver, if any, all physicians issuing orders and patient's primary care practitioner or health care professional who will provide care and services to patient after discharge, if any and indicated patients are notified of discharge as soon as possible prior to discharge as outlined in Notice of Non-Coverage, Expedited Determination and Reconsideration for Discharge Policy. 2. A review of agency policy "Coordination of Care, From Admit Through Discharge" indicated coordination of care		Coordination of Care, From Admit ThroughDischarge with emphasis on collaboration with the physician prior to dischargefrom services. Forany staff unable to attend the staff meeting, the ED will provide 1:1instruction by 2/16/24. Coordination of care with physician/authorizedpractitioner will occur throughout care and at discharge. Coordination of services is promoted through routinecommunication with the patient's physician when there is a need to change thepatient's plan of care; and at least every 60 days to review, revise, update,and/or continue the plan of care.	

	practitioner at admission, throughout care, and at discharge, coordination of services is promoted through routine communication with the patient's physician and indicated patient/caregiver will be notified regarding transfer / discharge. 3. The clinical record for Patient #3 included a plan of care (POC) for the certification period 12/28/23 to 2/25/24 with PT visit frequencies of 1 time a week for 2 weeks, 2 times a week for 3 weeks then 1 time a week for 4 weeks. The clinical record included a care coordination note dated 1/22/24 from the Quality review employee stating PT services have been denied by Patient #3's insurance. The care coordination note advised PT 1 to review patient's status and need for continued care and if addition treatment is determined, please update the account with supporting documentation for an additional request to Patient #3's insurance provider and stated discharge is not required at this time. A discharge note, completed by PT 1, dated 1/23/24 included		Revisions to the plan for a patient's discharge willbe communicated to all physicians issuing orders and the patient's primary carepractitioner or health care professional who will provide care and services topatient after discharge. The person ultimately responsible for implementing the plan ofcorrection is the Executive Director. Beginning the week of 2/18/24, the ED will review 5discharges per week to ensure the physician was notified and in agreement withdischarge in advance of discharge. Monitoring will continue for 12 weeks and until 100%compliant for 8 consecutive weeks.	

	documentation that Patient #3 was being discharged early due to payor dictated reason and indicated Patient #3 needs additional care to ensure full meeting of goals and safety in the home. The clinical record for Patient #3 failed to include any coordination with the physician prior to PT discharge from services. 4. During an interview on 1/24/24 beginning at 10:10 AM, PT 1 indicated they performed the PT services discharge for Patient #3 as advised by the office manager and indicated they did not collaborate with the attending physician prior to discharge. The physician was faxed after the PT discharge visit. 5. During an interview on 1/24/24 beginning at 11:10 AM, the Administrator confirmed the clinical record for Patient #3 failed to include any collaboration documentation with the physician prior to Patient #3 being discharged from physical therapy services.			
G1022	Discharge and transfer summaries	G1022	Occurrencereport was entered for patients #8, 9, and 10 for	2024-02-16

	484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. DPS: Based on record review and interview, the home health agency failed to send a transfer summary to the health facility to which the patient was transferred for 3 of 3 transferred patient records reviewed (Patient #8, #9, #10.) Findings include: 1. Policy #2.1.004 "Patient Discharge/Transfer Process", revised 10/01/23, relayed a transfer summary is to be sent to the primary care physician and the facility to which the patient is transferred within 2 business days of a planned transfer or becoming aware of an unplanned transfer. 2. Patient #8's clinical record		failure to submit a transfersummary to the facility the patient was transferred to. Duringa staff meeting held on 1/31/2024, the Executive Director (ED) reviewedfindings with clinical staff and educated on policy 2.1.004 PatientDischarge/Transfer Process with emphasis on ensuring a transfer summary is sentto the health facility to which the patient is transferring within 2 businessdays of a planned transfer or becoming aware of an unplanned transfer. Forany staff unable to attend the staff meeting, the ED will provide 1:1instruction by 2/16/24. A Transfer Summary is sent to the primary carephysician and the facility (if the patient is still receiving care in thefacility at the time the agency becomes aware of the transfer) to which thepatient is transferred within 2 business days of planned transfer or becoming awareof unplanned transfer.	

	failed to evidence a transfer summary was sent to the facility to which the patient was transferred. On 01/24/24 at 3:30 PM, the Administrator relayed a transfer summary had been sent to the primary care physician but not to the facility to which Patient #8 was transferred. 3. Patient #9's clinical record failed to evidence a transfer summary was sent to the facility to which the patient was transferred. On 01/24/24 at 3:30 PM, the Administrator relayed a transfer summary had been sent to the primary care physician but not to the facility to which Patient #8 was transferred. 4. Patient #10's clinical record failed to evidence a transfer summary was sent to the facility to which the patient was transferred. On 01/24/24 at 3:30 PM, the Administrator relayed a transfer summary had been sent to the primary care physician but not to the facility to which Patient #8 was transferred.		The person ultimately responsible for implementing the plan ofcorrection is the Executive Director. Beginning the week of 2/18/24. the ED will review 5transfers per week to ensure the Transfer Summary was sent to the facility. Monitoring willcontinue for 12 weeks and until 100% compliant for 8 consecutive weeks.	

	410 IAC 17-15-1(a)(6)			
N0000	Initial Comments This visit was a State Re-Licensure survey of a home health provider. Survey dates: January 22, 23, 24, 25, 2024 Unduplicated Skilled Admissions: 383	N0000		
N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the home health agency's organizational chart failed to readily identify administrative control and delegation of responsibility for the	N0440	Organizational chart was revised to reflect theGoverning Body (Executive Director) as having full legal authority andresponsibility for the agency's overall management and operation, and agency's qualityassessment and performance improvement (QAPI) program. Administrative and supervisory functions are notdelegated to other organizations or agencies. The Executive Director serves as the designated personso	2024-02-08

	home health agency for 1 of 1 agency. Findings include: 1. Policy #5.005 Organizational Responsibilities and Organizational Charts, revised 01/01/24, indicated administrative and supervisory functions were not to be delegated to other organizations and that the organizational chart is maintained, up to date, and defines appropriate lines of responsibility. The policy also relayed the relationship of administration and governing body are clearly defined in these documents and relayed the Executive Director serves as the designated person functioning as the Governing Body. 2. The agency's organizational chart included Corporate Person 3 at the top then down to Corporate Person then down to Corporate Person 4 then down to Corporate Person 5 then down to Corporate Person 1 who was directly above the Executive Director position in lines of authority. The organizational chart also indicated Corporate Person 1,		functioning as the governing body. The Executive Director assumes full legalauthority and responsibility for the agency's overall management and operation,provision of all home health services, fiscal operations, review of theagency's budget and operational plans and its QAPI program. An up-to-date organizational chart is maintained whichdefines appropriate lines of responsibility. The person ultimately responsible for implementing the plan ofcorrection is the Executive Director. Beginning 2/12/24, the QAPI team will review theorganizational chart quarterly to ensure it is current. Monitoring will continue for 3 consecutive quarters.	

	Corporate Person 4, Corporate Person 5, and Corporate Person 6 were responsible for Quality/Performance Improvement (QAPI). The organizational chart failed to evidence the Governing Body having full legal authority and responsibility for the agency's overall management and operation. The organizational chart failed to evidence the agency's Governing Body was responsible for the agency's QAPI program. 3. On 01/25/24 at 3:20 PM, the Administrator relayed Corporate Persons 1, 3, 4, 5, and 6 were not employees of the agency nor were they members of the governing body. The Administrator indicated he/she was the Governing Body and was responsible for the agency's QAPI program. The Administrator relayed the organizational chart depicted Corporate Persons 1, 4, 5, and 6 as responsible for the QAPI program. The Administrator indicated the copy of the organizational chart provided on 01/25/24 at 3:19 PM was the correct, current organizational chart for the agency.			

N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the home health agency failed to maintain an employee job description for 1 of 1 home health aide (HHA) employee records reviewed (HHA 1). Findings Include: 1. The review of the employee record for Home Health Aide 1,	N0458	Home Health Aide job description was previously signed10/30/23 and has been filed in the personnel file for HHA 1. The Executive Director (ED) educated the BusinessOffice Manager on the home health personnel file set up guide with emphasis on ensuringeach employee has a role specific job description provided and signed upon hireand when an employee's position changes; and these are filed in the personnelrecord. Upon hire, and upon change in position, each employee will be providedand sign a job description. A copy of the job description will be maintained inthe personnel file. The person ultimately responsible for implementing the plan ofcorrection is the Executive Director. Beginning 2/12/24, the ED will review all new employeepersonnel files from the prior month to ensure a job description was signed	2024-02-07

	evidenced a hire date of 2/20/23, with a first patient contact date of 12/16/23. The personnel filed failed to include a signed job description for HHA 1. 2. During an interview on 1/25/24 beginning at 11:29 AM the Administrator confirmed job description for HHA 1 was missing from the personnel file.		andpresent in the personnel file. Monitoring will continue for 3 months and until 100%compliance is achieved for 2 consecutive months.	
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented:	N0464	RN3to complete 2 step TB skin testing (TST) or Interferon-Gamma Release Assay(IGRA) by 2/16/24. Administrator,alternate administrator, PT 1, PTA 1, PT 2, OT 1, and RN 1 completed annual Tbscreening via TST or IGRA by 2/16/24. QAPITeam to be notified governing body has adopted CDC guidelines for TB screeningat next meeting scheduled for 2/23/24. TheExecutive Director (ED)	2024-02-23

	(i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on record review and interview, the home health agency failed to ensure all new hired employees having direct patient contact received the baseline two-step tuberculin skin test for 1 of 1 new hired		educated the Business Office Manager on 1/25/24 on TBtesting using policy 8.002 Respiratory Protection Plan, with emphasis on therequirement for an Interferon-Gamma Release Assay (IGRA) or two-step TuberculinSkin Test (TST) upon hire and annual screening via TST or IGRA. Upon hire, all health care workers engaging in patientcare will undergo TB testing by either an Interferon-Gamma Release Assay (IGRA)or a two-step Tuberculin Skin Test (TST).and will complete the TB Riskassessment. The second step of a two-step TST using the Mantoux method must beadministered one to three weeks	

	employees (RN 3) and failed to ensure all employees were screened for tuberculosis (TB, a contagious lung infection) annually including, at a minimum, a tuberculin skin test using the Mantoux method or a QuantiFERON-TB assay for 7 of 7 employee health files reviewed with employment greater than 1 year who provide patient care (Administrator, Alternate Administrator, PT 1, PT2, PTA 1, OT 1 and RN 1). Findings Include: 1. A review of agency policy "Staff Screening, New Hire and Annual" indicated all direct patient care staff or volunteers will be required to have an Interferon-Gamma Release Assay (IRGA), 2-step Tuberculin Skin Test (TST), tuberculin screen and/or chest X-ray, as deemed necessary, and based on the prevailing protocol used by the facility location. 2. The personnel health file for RN 3 indicated a hire date of 8/28/23 and the employee's duties included direct patient contact. The employee's health file included a TST test dated 9/05/23. The personnel health		after the first tuberculin skin test was administered.Persons who have previously had the Bacille Calmette-Geurin (BCG) TBvaccination will require the IGRA. Any person with a documented history oftuberculosis, previously positive test result for tuberculosis, or completionof treatment for tuberculosis, or newly positive results to the tuberculin skin test must have one CXRto exclude a diagnosis of tuberculosis. After baseline testing, tuberculosis screening must becompleted annually and include at a minimum, a TST using the Mantoux method ora QuantiFERON-TB assay. The person ultimately responsible for implementing the plan ofcorrection is the Executive Director. Beginning 2/26/24, the ED will review all new employeepersonnel files from the prior month to ensure a valid 2-step TST or IGRA	

	file for RN 3 failed to evidence a 2-step TST had been performed upon hire. During an interview on 1/25/24 beginning at 11:29 AM, the Administrator confirmed the personnel file for RN 3 failed to include 2-step TST documentation upon hire. 3. The personnel health file for the Administrator indicated a hire date of 5/10/16 and the employee's duties included direct patient contact. The employee's health file failed to evidence the agency screened the employee for TB annually. 4. The personnel health file for the Alternate Administrator indicated a hire date of 2/28/22 and the employee's duties included direct patient contact. The employee's health file failed to evidence the agency screened the employee for TB annually.		wascompleted on hire. Beginning 2/26/24, the ED will review 5 randompersonnel files for those having been employed > 1 year to ensure a validTST or IGRA was completed annually. Monitoring willcontinue for 3 months and until 100% compliant for 2 consecutive months.	

	5. The personnel health file for PT 1 indicated a hire date of 9/27/14 and the employee's duties included direct patient contact. The employee's health file failed to evidence the agency screened the employee for TB annually. 6. The personnel health file for PTA 1 indicated a hire date of 12/22/14 and the employee's duties included direct patient contact. The employee's health file failed to evidence the agency screened the employee for TB annually. 7. The personnel health file for PT 2 indicated a hire date of 2/18/20 and the employee's duties included direct patient contact. The employee's health file failed to evidence the agency screened the employee for TB annually. 8. The personnel health file for OT 1 indicated a hire date of 8/04/20 and the employee's duties included direct patient contact. The employee's health file failed to evidence the agency screened the employee for TB annually. 9. The personnel health file for			

	2/11/21 and the employee's duties included direct patient contact. The employee's health file failed to evidence the agency screened the employee for TB annually. 10. During an interview on 1/25/24 beginning at 11:29 AM, the Administrator confirmed the agency did not adopt a national standard for the surveillance of Latent TB in their healthcare staff who provide direct patient care and indicated they did not screen all employees for TB annually as required.			
N9999	Final Observations Based on record review and interview, the home health agency failed to ensure the home health aide (HHA 1) completed an approved dementia training program for 1 of 1 agency. Findings Include:	N9999	HHA1 will complete the approved dementia training program by 2/16/24. TheExecutive Director (ED) educated the Business Office Manager on 1/26/24 on the approveddementia training program that needs to be completed by a home health aide(HHA). Upon hire, all home health aides (HHA) will completean approved dementia training	2024-02-16

	1. The personnel file for HHA 1 indicated a hire date of 2/20/23 and a first patient contact date of 12/16/23. HHA 1's personnel record failed to evidence completion of an approved dementia training program. 2. During an interview on 1/25/24 beginning at 11:29 AM, the Administrator confirmed HHA 1 has not completed the required dementia training.		program no later than 60 days after the homehealth aide is hired to care for an individual with Alzheimer'sdisease, dementia, or a related cognitive disorder. The home health aide shallcomplete at least six hours of approved dementia training. Before December 31 of each year, a home health aidewho has been employed as a home health aide for at least one year shallcomplete at least three hours of approved dementia training. Home health aide dementia training courses will beauto assigned in the learning management system. The person ultimately responsible for implementing the plan ofcorrection is the Executive Director. Beginning 2/18/24, the ED will review all new HHApersonnel files from the prior month to ensure an approved dementia trainingprogram was completed.	

			Monitoring willcontinue for 3 months and until 100% compliant for 2 consecutive months.	

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
Wyndi Thompson	Quality Coordinator	2/9/2024 4:27:03 PM