STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K128	A. BUILDING B. WING	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEAM SELECT HOME CARE	8275 ALLISON POINTE TRAIL STE 350, INDIANAPOLIS, IN, 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Relicensure survey of a Home Health Provider. Survey Dates: 01-22-2023, 01-23-2023, 01-24-2023, and 01-25-2023 12-Month Unduplicated Skilled Admissions: 205 This deficiency report reflects State Findings cited in Accordance with 410 IAC 17. Refer to State Form for Additional state tags. QR Completed on 01/30/2024 by A4	G0000	**Team Select Home Care submits the following Plan of Correction as required by State and Federal law. Team Select's submission of this Plan of Correction should not be taken as an agreement with or admission of any of the findings contained therein. Team Select hereby expressly reserves the right to challenge the factual findings, legal conclusions, and allegations contained in the underlying reports. Compliance has been and will be achieved no later than the last completion date identified in the Plan of Correction.**	
G0490	Accessibility 484.50(f)(1,2)	G0490	Agency has provided the families of patients 3, 4 and 5 with their respective plan of care and medication profile and instructions in their preferred format. Agency	2024-02-24

Standard: Accessibility. Information must be provided to patients in plain language and in a manner that is accessible and timely to-

(1) Persons with disabilities, including accessible web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

(2) Persons with limited English proficiency through the provision of language services at no cost to the individual, including oral interpretation and written translations.Standard: Accessibility

Information must be provided to patients in plain language and in a manner that is accessible and timely to-

Based on record review and interview, the agency failed to ensure patients/caregivers were provided an option or given a preference in the way patient Plans of Care and Medication information and instructions were received, in 3 of 3 home visits. (Patients #3, #4, and #5)

Findings include:

1. Review of an agency document dated 08-05-2023, titled '1.1 Patient Rights' stated, "... The plan of care must be provided to the patient and/or his/her authorized representative (if any) no later than the next visit after the plan

will contact all

patients or their primary caregivers to ensure every patient

has access to their plan of care and medication list and

instructions in their preferred format.

All Agency clinical staff members have been re-educated

on the requirement to provide each patient with their plan

of care and medication profile and instructions in each

patient's preferred format. This education will continue to

be provided for all incoming clinical staff members as part

of the orientation and training process.

The DON will interview 10% of patients quarterly as part of

the Agency's QAPI program to ensure continued

compliance with this requirement.

The DON is responsible for monitoring these corrective

actions to ensure the deficiency is corrected and will not

recur.

	the physician... Clear written communication between the HHA and the patient and the patient's caregiver and authorized representative (if any) helps ensure that patients and families understand what services to expect from the HHA, the purpose of each service and when to expect the services ..." Review of an undated agency document titled 'CubHub Patient Portal Instructions' provided a web address with instructions to gain access to the agency's EMR and it's patient portal and create a password and username. Review of an undated agency document titled 'Client Portal CubHub Systems' contained 11 pages of detailed instructions on how to gain access to specific patient documents which included, but were not limited to: plan of care, assessments, and medication list. 2. On 01-22-2024 at 3:30 PM, during a home visit for Patient #3, Person A (a family member) when queried, indicated there			

	the home, was aware of a patient portal that could be accessed on the internet to view patient documents from the agency, but had not yet accessed this. On 01-23-2024 at 1:10 PM, during a home visit for Patient #5, Person B (a family member) when queried, indicated there was no current plan of care in the home provided by the agency. Person B indicated was aware of a patient portal that could be accessed on the internet to view patient documents from the agency, but had not yet accessed this. On 01-23-2023 at 4:45 PM, during a home visit for Patient #4, the patient when queried, indicated there was no current plan of care in the home provided by the agency. Patient #4 indicated had recently become aware of the patient portal that could be accessed online to view their documents from the agency, but had not accessed this yet. 3. On 01-24-2024 at 3:58 PM with the Administrator and Director of Nursing, when			

recent plans of care in the home, indicated the agency had provided access to a patient portal for patients/family use, but could not force them to utilize it.

On 01-25-2024 at 10:22 AM, the Director of Nursing indicated the transition to their new agency and new electronic medical records (EMR) system led to a change in the way plans of care were delivered to patients. This transition to the new EMR started approximately June 1, 2023 and since then, all new patients had been presented with a printed booklet (which contained, but was not limited to: patient rights, notice of privacy practices, advanced directive information, state hotline number to lodge complaints, administrator contact number, individualized emergency plan, and consent forms). Along with this booklet, an instruction sheet had been provided which explained how to access the patient portal. For existing patients who transitioned over to the new agency and new EMR, the Director of Nursing indicated during recertification or resumption, the nurses were

	"taking everything" out to the patients at those visits.			
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; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.	G0574	The plan of care for patient #1 has been updated to include the proper unit of measurement for body weight, clarification on duplicate instances of the same drugs, additional instructions for use of nitro paste, and a completed protocol for the patient's autonomic dysreflexia. The plan of care for patient #3 has been updated to include the unit of measurement for weight and to clarify the duplicate medication doses. These updated orders have been sent to the patients' physicians for countersignature. The Agency has completed a 100% review of medication lists to ensure any duplicate medications are appropriately clarified and any medications used in a systematic response plan have clear and thorough instructions. The DON will review 100% of new plans of care and medication lists for 60 days to ensure continued compliance with these requirements. The DON will include a review of medication lists, weight and [patient-specific	2024-02-05

	Based on record review and interview the agency failed to ensure patients' medication, weight, and safety measures to protect against injury were accurately reflected on the Plan of Care/485, in 2 of 5 active charts reviewed. (Patient #1 and #3) Findings include: 1. Review of an agency policy dated 08-05-2023, titled '2.6 - Plan of Care' stated, "POLICY Service will be provided in accordance with a written Care Plan based on the patient's diagnoses and assessment of immediate and long-range needs and resources ... PROCEDURE There is a written Plan of Care established based on the assessment of the patient ... The plan of care includes: ... nutritional requirements, medications and treatments ... Education and safety measures ..." 2. Review of the clinical record for Patient #1, certification period of 01-18-2024 through 03-17-2024. Non-skilled home health aide services were ordered 4-6 days per week for		response procedures in the 10% quarterly clinical record audit as part of the Agency's QAPI program to ensure compliance is maintained. The DON is responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

	nine weeks. The plan of care dated 01-16-2024 contained a list of the patient's current medications which included, but not were limited to: "... baclofen 10 mg Oral 1-2 tablets TID (three times daily) Muscle Relaxer Take 1-2 tablets TID – 6/20/2023", "baclofen 20,000 mcg/ 20 ml (1,000 mcg/ ml intrathecal (injection into the spinal canal) 36 mcg/day (1.5mcg/ hr) Daily Pain from muscle spasms Baclofen pump to be injected intrathecally in MD office. – 7/25/2023 ...". The medication list also contained, "... Docusate [Colace] 100 mg 1 capsule BID (twice daily) Constipation – 6/10/2023 ..." and, "... docusate sodium 100 mg Oral 1 tablet BID Constipation – 6/10/2023 ..." A section titled 'Nutritional Requirements' stated, "16. Current Weight: 170" and failed to evidence a unit of measurement. A section titled '15. Safety Measures' failed to evidence a protocol/action plan for the patient's Autonomic Dysreflexia. A section titled '21. Orders for Disciplines and Treatments stated, "Autonomic Dysreflexia Action Plan - Follow up with Neurology and use Nitro Paste			

	(nitroglycerin in paste form, the recommended initial emergency treatment of severe hypertension in patients with autonomic dysreflexia) PRN". The action plan failed to evidence further instruction on the use of Nitro Paste (found in the medication list, "nitroglycerin 0.02 mg/mg Topical Apply 1-inch SBP (systolic blood pressure) >180 and remove when SBP decreases to 140 PRN (as needed) 2-3 times in 45 minutes Autonomic Dysreflexia Apply to a 1-inch space on the forehead". The plan failed to evidence other interventions to remove/reduce triggers, and failed to evidence further instructions should the 3 attempts to use Nitro Paste fail to resolve the emergent episode. In total, the plan of care failed to evidence an explanation for duplicate instances of the same drugs, failed to include a unit of measurement for the patient's weight, and failed to contain a completed protocol/action plan for the patient's autonomic dysreflexia. 3. Review of the clinical record			

	period of 12-07-2023 through 02-04-2-24 included but was not limited to: Skilled private-duty nursing was ordered five (5) times per week for nine (9) weeks. The plan of care dated 12-06-2024 contained a medication list which included but was not limited to: "... Haleigh's Hope CBD oil (15:1) 1gm/1ml Enteric – GB (gastrostomy button) 2ml QD seizures – 6/7/2023 ..." And, "... Haleigh's Hope CBD oil (15:1) 1gm/1ml Enteric – GB (gastrostomy button) 1.5 ml QD seizures – 10/6/2023 ..." The plan of care also evidenced, "... Current Weight: 50 ..." The record failed to evidence an explanation for duplicate instances of the same medication and failed to include a unit of measurement for the patient's body weight. 4. In an interview on 01-23-2024 at 3:30 PM, during a home observation for Patient #3, Person A, the primary caregiver, when queried as to the duplicated entries of CBD oil appearing on the plan of care, indicated knew the difference and explained the 2ml dose was to be administered with the patient's			

	afternoon feeding and the 1.5 ml should be given with the night feeding. 5. On 01-24-2024 at 11:37 AM, the Alternate Administrator/Director of Nursing and Alternate Director of Nursing indicated were unaware of duplicated medications and the lack of a unit of measurement for body weight for Patient #1 and Patient #3 being carried over inaccurately to the plan of care from the comprehensive assessment, and indicated they suspected this to be a glitch in the new EMR (Electronic Medical Records) system but would investigate further and put in a ticket with the EMR vendor. Both indicated these discrepancies should have been caught. 6. On 01-24-2024 at 1:41 PM when queried as to what should be expected in an Autonomic Dysreflexia protocol/action plan for Patient #1, the Alternate Administrator/Director of Nursing indicated this patient was receiving only home health aide services, and would expect the aide would not apply medications, would notify any			

	family present in the home and/or other pertinent family members, would call the nurse in the office to report any changes in the patient, and the aide could call 911. 7. On 01-25-2024 at 11:45 AM when queried regarding Patient #1 and the duplicate entries of baclofen and docusate on Patient #1's Plan of Care medication list, Registered Nurse (RN) 2 indicated had also noticed duplications of medication appearing on patient's plans of care. Also indicated there should have only been one (1) instance of Docusate, confirmed the two (2) instances of Baclofen were accurate, and indicated there should be a further explanation as to why the medications appeared twice. Regarding Patient #1's autonomic dysreflexia protocol/action plan, RN 2 indicated patient's family member/primary caregiver is the one who would administer the Nitro Paste to the patient and RN 2 had already placed a call to the provider for further orders and instructions regarding next steps after the Nitro Paste is given and the episode remains unresolved, for			

	example whether to call an ambulance or the doctor. Indicated further would be including instructions to ensure the home health aide is not to touch nor administer any medication. Reiterated the family member knows how to administer the medication and how to take the patient's blood pressure as well. 410 IAC 17-13-1(D)(viii,ix,x)			
G0612	Written instructions to patient include: 484.60(e) Standard: Written information to the patient. The HHA must provide the patient and caregiver with a copy of written instructions outlining: Based on record review and interview the agency failed to ensure patients/caregivers received their most recent plans of care for 3 of 3 home visits observed. (Patients #3, #4, and #5) Findings include: 1. Review of an agency document dated 08-05-2023, titled '1.1 Patient Rights' stated,	G0612	Agency has confirmed that all Agency patients have been provided with a current copy of their plan of care, including patients 3, 4 and 5 identified in the survey. All RNs responsible for completing patient admissions and re-certifications have been re-educated on the requirement to provide each patient with a current copy of their plan of care. This education will continue to be provided to all incoming RNs responsible for patient admissions and recertifications as part of the training and onboarding process. The DON will review all admission and recertification visit	2024-02-24

	"... The plan of care must be provided to the patient and/or his/her authorized representative (if any) no later than the next visit after the plan of care has been approved by the physician... Clear written communication between the HHA and the patient and the patient's caregiver and authorized representative (if any) helps ensure that patients and families understand what services to expect from the HHA, the purpose of each service and when to expect the services ..." 2. On 01-23-2024 at 3:30 PM, during a home visit for Patient #3, Person A (a family member) when queried, indicated there was not a current plan of care in the home, was aware of a patient portal that could be accessed on the internet to view patient documents from the agency, but had not yet accessed this. On 01-23-2024 at 1:10 PM, during a home visit for Patient #5, Person B (a family member) when queried, indicated there was not a current plan of care in the home provided by the agency. Person B indicated was		notes for 60 days to ensure documentation reflects that all patients have been provided with a copy of their plan of care. The DON will interview 10% of patients quarterly as part of the clinical record audit to ensure ongoing compliance with the requirement to provide each patient with a copy of their plan of care. The DON is responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

	aware of a patient portal that could be accessed online to view patient documents from the agency, but had not yet accessed this. On 01-23-2023 at 4:45 PM, during a home visit for Patient #4, the patient when queried, indicated there was not a current plan of care in the home provided by the agency. Patient #4 indicated had recently become aware of the agency's patient portal that could be accessed online to view their own documents, but had not yet accessed this. 3. On 01-25-2024 at 10:22 AM, the Alternate Administrator/Director of Nursing indicated the recent transition to their new agency and new electronic medical records (EMR) system led to a change in the way plans of care were delivered to patients. This transition to the new EMR started approximately June 1, 2023, and since then all new patients had been presented with a printed booklet (which contained, but was not limited to: patient rights, notice of privacy practices, advanced			

	hotline number to lodge complaints, administrator contact number, individualized emergency plan, and consent forms). Along with this booklet, an instruction sheet had been provided which explained how to access the patient portal. For existing patients who transitioned over to the new agency and new EMR, the Director of Nursing indicated upon recertification or resumption, the nurses were "taking everything" out to the patients at those visits so patients could have access to their own documents which included but were not limited to: plans of care and medication lists.			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on record review and interview the agency failed to ensure patients/caregivers had received a recent medication list, in 3 of 3 home visits	G0616	Agency has confirmed that all Agency patients have been provided with a current copy of their medication list, including patients 3, 4 and 5 identified in the survey. All RNs responsible for completing patient admissions and re-certifications have been re-educated on the requirement to provide each patient with a current copy of their medication list. This education will continue to be provided to all incoming RNs responsible for patient	2024-02-24

observed. (Patients #3, #4, and #5)

Findings include:

1. Review of an agency policy dated 08-05-2023, titled '2.6 - Plan of Care' stated, "POLICY Service will be provided in accordance with a written Care Plan based on the patient's diagnoses and assessment of immediate and long-range needs and resources ... PROCEDURE There is a written Plan of Care established based on the assessment of the patient ... The plan of care includes: ... nutritional requirements, medications and treatments ..."

2. On 01-23-2024 at 3:30 PM, during a home visit for Patient #3, Person A (a family member) when queried, indicated there was not a current medication list in the home, was aware of a patient portal that could be accessed on the internet to view such patient documents from the agency, but had not yet accessed this.

3. On 01-23-2024 at 1:10 PM, during a home visit for Patient #5, Person B (a family member) when queried, indicated there

admissions and

recertifications as part of the training and onboarding

process.

The DON will review all admission and recertification visit

notes for 60 days to ensure documentation reflects that all

patients have been provided with a copy of their current

medication list. The DON will interview 10% of patients

quarterly as part of the clinical record audit to ensure

ongoing compliance with the requirement to provide each

patient with a copy of their recent medication list.

The DON is responsible for monitoring these corrective

actions to ensure the deficiency is corrected and will not

recur.

	was not a current medication list in the home provided by the agency. Person B indicated was aware of a patient portal that could be accessed on the internet to view such patient documents from the agency, but had not yet accessed this. 4. On 01-23-2023 at 4:45 PM, during a home visit for Patient #4, the patient when queried, indicated there was not a current medication list in the home provided by the agency. Patient #4 indicated had recently become aware of the patient portal which could be accessed via the internet to view their documents from the agency, but had not accessed this yet. 5. On 01-25-2024 at 10:22 AM, the Alternate Administrator/Director of Nursing indicated the transition to their new agency and new electronic medical records (EMR) system led to a change in the way plans of care were delivered to patients. This transition to the new EMR started approximately June 1, 2023 and since then all new patients have been presented			

	contained, but was not limited to: patient rights, notice of privacy practices, advanced directive information, state hotline number to lodge complaints, administrator contact number, individualized emergency plan, and consent forms). Along with this booklet, an instruction sheet was provided which explained how to access the patient portal where the patient's plan of care and medication list can be viewed. For existing patients who transitioned over to the new agency and new EMR, the Director of Nursing indicated upon recertification or resumption, the nurses were "taking everything" out to the patients at those visits so patients could have access to their documents which included but were not limited to: plans of care and medication lists.			
G0682	Infection Prevention 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.	G0682	CNA #1 has completed a re-competency verification for bathing and infection control and has successfully demonstrated competency in both tasks. RN #2 has completed a re-competency verification for g-tube med	2024-02-05

	Based on observation, record review, and interview the agency failed to ensure staff adhered to infection prevention standards in 2 of 3 home visits observed. (Patients #3 and #5) Findings include: 1. Review of an agency document dated 08-06-2023, titled '3.5 Standard Precautions' stated, "POLICY Blood and body fluid precautions will be followed for all patients. PURPOSE To prevent transmission of communicable diseases ... Standard Precautions include the following procedures: All health care workers will routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact with blood or any other body fluids of any patient is anticipated. Gloves will be worn before touching body blood and body fluids, mucus membranes or non-intact skin of all patients: for handling items or surfaces soiled with blood and body fluids; ..." Review of an agency document dated 08-06-2023, titled '3.6 - Hand Hygiene / Hand Washing		administration and infection control and has successfully demonstrated competency in both tasks. Verification of each competency has been added to the employees' personnel records. All Agency employees, including CNA #1 and RN #2 have been re-educated on the importance of adhering to infection control standards to promote patient safety. This education will be required annually and will continue to be provided to all incoming employees who provide direct care. Safe completion of patient care tasks and adherence to infection control standards will continue to be monitored during all patient visits where an employee is providing care. All direct care employees will continue to complete an initial and annual skills competency evaluation to verify safe and proper completion of patient care tasks as well as adherence to infection control standards. The DON and Administrator will audit 100% of new employee files for 60 days to ensure competency verification is present. The DON and Administrator will audit 10% of personnel files quarterly as part of the Agency's QAPI	

	/ Hand Cleansing' stated, "POLICY Hand Hygiene / Hand Washing / Hand Cleansing will be done by all employees to reduce the transfer of microbes to patients and to prevent the growth of microorganisms on the nails, hands and forearms. PURPOSE To prevent transfer of germs and transmission of infections to patients and caregivers. PROCEDURE 1. Indications for Hand Hygiene / Hand Washing / Hand Cleansing are: before and after direct patient care, before and each procedure ... When hands are soiled ... After any contact with contaminated materials ... 2. All employees are responsible for implementing Hand Hygiene / Hand Washing / Hand Cleansing procedures in an on-going attempt to prevent and/or contain infectious processes and communicable diseases ..." 2. On 01-22-2024 at 3:30 PM during a home visit for Patient #3, Registered Nurse (RN) 2 was observed preparing medications for gastrotomy tube (G-tube: a tube inserted directly into the belly that brings nutrition directly to the stomach)		program to ensure compliance is maintained. The DON and Administrator are responsible for monitoring these corrective measures to ensure the deficiency is corrected and will not recur.	

	administration by prefilling liquid medications into empty, needless syringes. Gloves were donned and the filled syringes were brought to the patient's chairside. Using a gloved right hand to grasp the underside of the seat of a rolling stool, the nurse pulled this stool closer to the patient's chair to sit near them. Using the same gloved right hand, the nurse proceeded to attach a length of extension tubing to the feeding port of the G-tube, proceeded to administer all the prepared medications, and ended with a water flush. The nurse then disconnected the extension tubing and closed the feeding port using the same gloved right thumb and forefinger. 3. On 01-23-2024 at 1:10 PM during a home visit for Patient #5, Certified Nurse Assistant (CNA) 1 was observed preparing to provide a bed bath for the patient. The CNA properly washed and dried their hands then a single basin of reportedly warm water was prepared for the patient. The basin was brought into the room and placed alongside the patient. The CNA donned gloves. The			

	washcloth, dipped into the water-filled basin, and began to cleanse the patient's eyes, working their way down the front of the torso, applying soap to the washcloth with each new section of the body cleansed, finishing with the patient's back, the basin becoming increasingly foamy. The CNA continued the bed bath, transitioning to a dark washcloth for the patient's perineal area and lower body. The basin's water was not exchanged for fresh water and the aide's gloves were not changed for the duration of the bed bath. 4. On 01-24-2024 at 3:58 PM, the Administrator and Alternate Administrator/Director of Nursing indicated were aware of the infection control breach during the visits with Patient #3 and RN 1, and indicated they would have expected the nurse would have washed their hands and re-gloved after touching the chair. Indicated further they were also aware of the infection control breach with Patient #5 and CNA 1, and indicated would have expected the use of two basins during a bed bath (one for rinse water), and that gloves			

	frequently and at appropriate intervals. 5. On 01-24-2024 at 6:08 PM in a returned phone call, RN 1, indicated after handling Patient #3's stool/chair, should have taken a moment to remove gloves, sanitize hands, re-glove, then start again. 6. On 01-25-2024 at 12:00 PM, CNA 1 indicated knew two basins were needed for Patient #5, but the patient is normally taken to the shower for their bathing. Indicated would have ideally changed their gloves more often during the visit but had been very nervous, had already received re-education and been able to perform an extensive bed bath with reinforcement from the case managing nurse. 410 IAC 17-12-1(m)			
G1022	Discharge and transfer summaries 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	G1022	A completed discharge summary for patient #6 was sent to the physician. The DON completed a 100% audit of patients discharged in the last 6 months and found that all other records were	2024-01-29

	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. Based on record review and interview the agency failed to ensure a discharge summary was completed and sent to the physician within 5 days upon discharge, in 1 of 2 closed records reviewed. (Patient #6) Findings include: 1. Review of an agency document dated 08-06-2024, titled '2.24 - Discharge Summary' stated, "POLICY A discharge summary will completed for all patients discharged from the Agency. PURPOSE To record a summary of care received by the patient from the start of care through discharge. PROCEDURE 1. The discharge summary form will be completed by the Skilled Nurse ... The Discharge Summary will included but us not limited to: Discharge date ... reason for discharge ... Status of		compliant with the requirement to submit a completed discharge summary to the physician. All RNs responsible for processing discharges have been re-educated on the requirement to complete the discharge summary and send it to the physician. This education will continue to be provided to all incoming RN Case Managers as part of the orientation and training process. The DON will review 100% of discharges for 60 days to ensure continued compliance with the discharge summary requirement. The DON will include a sample of discharged records in the quarterly 10% clinical record audit as part of the Agency's QAPI program to ensure compliance is maintained. The DON is responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

	problems identified throughout the course of care ... Patient's overall status ... Instructions given to the client ... A summary of care or services provided ... 2. The physician will be informed of the availability of the Discharge Summary. 3. The Discharge Summary Form from each service, as applicable, will be filed in the medical record and a copy forwarded to the physician upon request." 2. Review of the closed clinical record for Patient #6 evidenced a start of care date of 02-17-2022 with a discharge date of 12-06-2023. The record failed to evidence a discharge summary had been completed. 3. On 01-25-2024 at 10:26 AM, when queried as to the discharge summary for Patient #6, the Alternate Administrator/Director of Nursing indicated after further review it appeared the nurse on the case, Registered Nurse (RN) 3 had not completed this discharge summary timely, but had communicated with the patient's provider and case manager upon discharge. Also			

	complete the document and the resulting discharge summary would be sent to the provider, and indicated an audit of all discharged patients would ensue. 410 IAC 17-15-1(a)(6)			
N0000	Initial Comments This visit was for a State Relicensure survey of a Home Health Provider. Survey Dates: 01-22-2023, 01-23-2023, 01-24-2023, and 01-25-2023 12-Month Unduplicated Skilled Admissions: 205	N0000	**Team Select Home Care submits the following Plan of Correction as required by State and Federal law. Team Select's submission of this Plan of Correction should not be taken as an agreement with or admission of any of the findings contained therein. Team Select hereby expressly reserves the right to challenge the factual findings, legal conclusions, and allegations contained in the underlying reports. Compliance has been and will be achieved no later than the last completion date identified in the Plan of Correction.**	
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	N0458	National criminal backgrounds have been run for the Administrator and DON, and completed backgrounds have been added to their respective personnel records. The Agency has completed a 100% audit of	2024-02-01

	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 agency failed to conduct 'National' or 'Expanded' criminal background checks for the Administrator and Alternate Administrator/Director of Nursing, in 1 of 1 agency surveyed. Findings include: 1. A review of an agency document dated 08-06-2024, titled '7.9 - Personnel Records' stated, "... Criminal history background checks will be obtained on all contract staff and all individuals seeking employment with the Agency and will be conducted not more than 90 days prior to		employee files and has confirmed that all records are complinat with the requirement to include a copy of a national criminal background check, pursuant to IC 16-27-2. The Administrator will audit 100% of new employee files for a period of 60 days to ensure continued compliance with this requirement. The Administrator will review national background checks during the 10% quarterly personnel record audit as part of the Agency's QAPI program to ensure ongoing compliance. The Administrator is responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

	employment of the individual ..." 2. A review of the personnel file for the Administrator evidenced a Limited Criminal background check performed on 09-02-2014, and none thereafter. 3. A review of the personnel file for the Alternate Administrator/Director of Nursing evidenced a Limited Criminal background check performed on 03-05-2015, and none thereafter. 4. On 01-24-2024 at 2:38 PM, the Administrator indicated was not aware that an 'Expanded' or 'National' criminal background check was required of his position and of the Alternate Administrator/Director of Nursing. Indicated would explore this further.			

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
John Cosgrove	Administrator	2/9/2024 10:00:45 AM