STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157597	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE SOLUTIONS LLC	5250 E US 36 STE 710, AVON, IN, 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: 08-13, 08-14, and 08-15-2024. Active Census: 257 At this Emergency Preparedness survey, Home Health Care Solutions, LLC was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers at 42 CFR 484.102. QR completed by Area 3 on 8-19-2024.	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal	G0000		

	Recertification and State Re-Licensure Survey of a Home Health Provider. Survey dates: 08-13-2024, 08-14-2024, and 08-15-2024. Facility number: 007288 12-Month Unduplicated skilled admissions: 1733 QR completed by Area 3 on 8-19-2024.			
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 observation, record review, and interview, the agency failed to ensure physician wound orders were followed according to the plan of care for 1 of 1 active clinical record review with a home visit of a Skilled Nurse providing wound care. (Patient #11) Findings Include: 1. An undated policy titled	G0580	G 0580 Agency reviewed all findings for not meeting the element of ensuring physician wound orders were followed according to the Plan of Care. These findings were shared during the exit meeting on 08/15/2024 by the State Surveyors. Therefore, we started implementing a plan to ensure physician orders are being followed per plan of care. Patient #11's clinical record was updated on 08/15/2024 with a verbal order from following NP stating NS could be substituted for Vashe solution effective 08/12/2024. Education sent out to all nursing staff regarding use of wound cleansing products, what to do in the event that patient runs out of ordered cleansing product by calling the following Physician to obtain an order for a substitution product prior to use. Continuing staff education will be given during quarterly nurse meetings and weekly Wound Wednesday kmails. Wound Wednesdays are weekly snippets of education created by ADON and WOCN as a response to requested continuing education from staff and standards of practice. Process Improvement Plan (PIP) created on 08/23/2028 by DON/ADON to address this	2024-09-13

	"Wound Care, Policy Number: C 313" indicated but was not limited to, " ... Continued/Ongoing Treatment, 1. Nurse will provide wound care per physician orders ..." 2. On 08-14-2024 at 11:45 AM, Licensed Practical Nurse (LPN) 1 was observed providing wound care for Patient #11 at their residence. A bottle labeled Simply Saline Wound Wash was used by LPN 1 to cleanse Patient #11's wound on their right lower leg. 3. A review of Patient #11's clinical record evidenced a Plan of Care (POC), Start of Care (SOC) date 07-17-2024, and an initial certification period from 07-17-2024 to 09-14-2024. The diagnoses listed in the POC included but were not limited to Type 2 Diabetes Mellitus (a disease where the body is unable to appropriately use sugar) with a skin ulcer (an open wound in the skin with potential to cause damage to tissue) and ulcer of the right lower leg with the fat layer exposed. The POC evidenced the patient had Skilled Nursing visits 2 times a week for wound care. The POC		deficiency and will be shared with QAPI Team. QA Team will verify correct treatment/medications listed on patient profile when uploading new wound care orders to the chart and report any discrepancies to DON/ADON daily. ADON/WOCN will audit all wound care charts monthly to ensure POC is followed per MD order and report monthly findings and effectiveness of continued education to DON. All wound care orders will be followed at 100%, the effectiveness of the PIP will be assessed in QAPI meetings after 6 months starting on 09/18/2024, and if goals are not achieved, then PIP will continue another 6 months. Date this deficiency will be corrected by 09/13/2024.	

	was cleansed with Vashe (a wound cleansing solution that assists in fighting infection). A review of Patient #11's clinical record evidenced documents titled "Wound Care Worksheet" dated 08-12-2024 and 08-14-2024 and signed by LPN 1 evidenced the patient's right lower leg wound was cleansed with Normal Saline. Patient #11's clinical record failed to evidence orders for the clinician to substitute Normal Saline for Vashe to cleanse the patient's wound. 4. On 08-15-2024 at 12:10 PM, an interview with LPN 1 evidenced they used Normal saline to cleanse Patient #11's right lower leg wound on 08-14-2024. They indicated the patient had to buy Vashe, and if the supply was not in the home it could not be used. 5. During an interview with Registered Nurse (RN) 1 on 08-15-2024 at 12:35 PM, they indicated they admitted Patient #11 to the agency. RN 1 indicated LPN 1 communicated with them consistently and indicated the LPN was to inform			

	the home. RN 1 confirmed they were not informed the LPN was using Normal Saline instead of the Vashe for Patient #11. On 08-15-2024 at 3:28 PM, LPN 1 called back and indicated they used the Vashe on Patient #11 until last Wednesday, 08-07-2024, and switched to Normal Saline on 08-12-2024. 6. During an interview with the Administrator on 08-15-2024 at 3:40 PM, they indicated the order for Normal Saline should have been sent on 08-12-2024 for Patient #11. They confirmed the clinical record failed to evidence an order for Normal Saline to be used as a substitute for Vashe for the patient's wound care. 410 IAC 17-13-1(a)			
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. Based on record review and	G0682	G 0682- Agency reviewed all findings for not meeting the element of implementing a nationally recognized standard for transmission of communicable diseases as related to Tuberculosis Screening of Employees of a HHA. These findings were shared during the exit meeting on 8/15/2024 by the State Surveyors. The Agency created a clear policy to maintain infection prevention following CDC Guidelines.	2024-09-13

	interview the agency failed to implement a nationally recognized standard for transmission of communicable diseases as related to tuberculosis screening of employees of a home health agency. Findings include: 1. A review of a policy titled 'Management of Infections/Exposure in Personnel IC 612' stated, " . . . " 1. " b. All patient care personnel will complete a screening questionnaire for pulmonary symptoms on an annual basis ... 5. ... The agency shall maintain records on appropriate personnel but is not limited to, a record of TB skin testing, any personal exposure incidents, medical evaluation and treatment as applicable ..." 2. Review of personnel record PT 2 (Physical Therapist #2) evidenced most recent annual tuberculin risk assessment date 02-18-2021. 3. Review of personnel record LPN 1 (Licensed Practical Nurse #1) evidenced no annual		Agency created a policy HR 707 Employee Health- TB Screening on 8/21/2024, which clearly states initial and annual requirements for TB assessment and screening following CDC National Standard. Physical Therapist #2 and Licensed Practical Nurse #1 submitted their annual tuberculin risk assessment tool on 8/27/2024 to update personnel file according to Agency policy. Human Resource will audit all employee files for compliance by 09/18/2024. Agency reviewed all policies and procedures related to deficiency to ensure compliance. On 8/28/2024 an operations committee will meet to review policy HR 707 by all QAPI Team/board. Process Improvement Plan (PIP) created by DON/ADON on 8/21/2024 for HR to review all employee files every 6 months for 1 year starting on 09/18/2024 and report findings to Administrator/DON/ADON. Administrator/DON/ADON will be responsible for ensuring HR employee files are up to date and compliant annually even after successful completion of PIP. Date this deficiency will be corrected by 09/13/2024.	

	the record. 4. Interview with Administrator on 08-15-2024 at 1:50 PM, when queried about the process for tuberculin risk assessment requirements, the Administrator reported all staff get a baseline tuberculin skin test and annually complete a tuberculin risk screening assessment as per policy. When queried about what national standard was used for their agency on tuberculin skin test and screening, the Administrator said to go ask Human Resources, Administrator 2. 5. During an Interview with Admin 2 (administrative staff #2) on 08-15-2024 at 3:20 PM, when queried about what national standard is followed for tuberculin skin test and screening, Admin 2 stated agency staff from the facility usually do the tuberculin test and was not sure what was meant by national standard followed for tuberculin policy and that a national standard was not being used. 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 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 transfer summaries were sent to the physician or health care entity providing care for 3 of 3 discharged records reviewed who transferred to an inpatient facility. (Patients #13, 14, and 15) Findings Include: 5. A review of Patient #14's discharge clinical record evidenced a document titled "OASIS-E Transfer" dated and signed by Registered Nurse (RN) 2 on 06-26-2024. The	G1022	G 1022 Agency reviewed all findings for not meeting the element of sending a Transfer Summary to the Physician or Healthcare entity providing care. These findings were shared during the exit meeting on 08/15/2024 by the State Surveyors. Therefore our Agency started assigning a Transfer Summary along with each Transfer Oasis to be completed and sent to the following Physician within 2 days of Agency becoming aware of Transfer. Agency reviewed Discharge/Transfer Policy related to the deficiency and found it to be in compliance. Going forward agency will follow Transfer and Discharge Policy C334 and sent to all staff for re-education on 08/27/2024. ADON educated all staff on 08/22/2024 regarding addendum of Transfer Summary process. ADON will monitor assignment of Transfer Summaries and ensure that 100% of Transfer Oasis include Transfer Summaries. QA will ensure 100% of Transfer Summaries are sent to following MD after staff completion. ADON will monitor transfers monthly and report findings to DON. Date this deficiency will be corrected by 09/13/2024.	2024-09-13

transferred from the agency on 06-26-2024 to the hospital, Entity 7.

Patient #14's discharge clinical record failed to evidence a discharge summary was sent to the patient's physician, Person 9, on 06-26-24. The clinical record failed to evidence a transfer summary was sent to the hospital, Entity 7.

410 IAC 17-15-1(a)(7)

1. An undated policy titled "Transfer and Discharge Services, Policy Number: C334" indicated but was not limited to, " ... Documentation ... When a patient is ... transferred ... to another organization, relevant information includes at least ... A. Reason for transfer or discharge. B. Physical and psychosocial status at time of transfer or discharge. C. Summary of the care/services provided and progress toward achieving goals. D. Instruction and/or referral provided to the patient. E. A complete list of medications was provided to the patient ... 4. A copy will be forwarded to the attending

	physician ..." 2. A review of Patient #15's discharge clinical record evidenced a document titled "OASIS-E Transfer" dated and signed by Registered Nurse (RN) 2 on 06-26-2024. The document indicated the patient discharged from the agency on 06-26-2024 and was transferred to the hospital, Entity 5. Patient #15's discharge clinical record failed to evidence a transfer summary was sent to the patient's physician, Person 6. 3. A review of Patient #13's discharge clinical record evidenced a document titled "OASIS-E Transfer" dated and signed by Physical Therapist (PT) 3 on 07-18-2024. The document indicated the patient discharged from the agency on 07-18-2024 and was transferred to the hospital, Entity 7. Patient #13's discharge clinical record failed to evidence a transfer summary was sent to the patient's physician, Person 8. 4. During an interview with the			

	2:55 PM, when queried regarding a transfer summary for discharged Patients #13, #14, and #15, they indicated they had not heard of a transfer summary and only sent the physicians the medication profile. On 08-15-2024 at 4:05 PM, the Administrator explained "OASIS-E Transfer" documents were not sent to the physicians when a patient transferred, the physicians were faxed the medication lists.			
N0000	Initial Comments This survey visit was for a home health re-licensure survey. Survey dates: 08-13-2024, 08-14-2024, and 08-15-2024. 12-Month Unduplicated skilled admissions: 1733 QR completed by Area 3 on 8-20-2024.	N0000		

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: (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	N0464	N 0464- Agency reviewed all findings for not meeting the element of Rule 12 Section 1 regarding Tuberculosis Evaluation and Screening. These findings were shared during the exit meeting on 8/15/2024 by the State Surveyors. Therefore our Agency started implementing a plan to create a clear policy regarding Rule 12 Section 1. Agency created a policy HR 707 Employee Health- TB Screening on 8/21/2024, which clearly states initial and annual requirements for TB assessment and screening following CDC National Standard. Physical Therapist #2 and Licensed Practical Nurse #1 submitted their annual tuberculin risk assessment tool on 8/27/2024 to update personnel file according to Agency policy. Human Resource will audit all employee files for compliance by 09/18/2024. Agency reviewed all policies and procedures related to deficiency to ensure compliance. On 8/28/2024 an operations committee will meet to review policy HR 707 by QAPI Team/board. Process Improvement Plan (PIP) created on 8/21/2024 by DON/ADON for HR to review all employee files every 6 months for 1 year starting on 09/18/2024 and report findings to Administrator/DON/ADON. Administrator/DON/ADON will be responsible for ensuring HR employee files are up to date and compliant annually even after successful completion of PIP. Date this deficiency will be corrected by 09/13/2024.	2024-09-13

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 agency failed to ensure employees, staff members, persons providing care on behalf of the agency having direct patient care completed a tuberculosis risk screening for 2 of 7 personnel records reviewed

1. A review of a policy titled 'Management of Infections/Exposure in Personnel IC 612' stated, " . . . " 1. " b. All patient care personnel will complete a screening questionnaire for pulmonary symptoms on an annual basis ... 5. ... The agency shall maintain records on appropriate personnel but is not limited to, a record of TB

exposure incidents, medical evaluation and treatment as applicable ..."

2. Review of personnel record for PT 2 Physical Therapist #2) evidenced most recent annual tuberculin risk assessment date 02-18-2021.

3. Review of personnel record for LPN 1 (Licensed Practical Nurse #1) evidenced no annual tuberculin risk assessment in the record.

4. Interview with Administrator on 08-15-2024 at 1:50 PM, when queried about the process for tuberculin risk assessment requirements, the Administrator reported all staff get a baseline tuberculin skin test and annually complete a tuberculin risk screening assessment as per policy. When queried about what national standard was used for their agency on tuberculin skin test and screening, the Administrator said to go ask Human Resources, Administrator 2.

5. During an Interview with Admin 2 (administrative staff #2) on 08-15-2024 at 3:20 PM, when queried about what national standard is followed for

	tuberculin skin test and screening, Admin 2 stated agency staff from the facility usually do the tuberculin test and was not sure what was meant by a national standard followed for tuberculin policy and a national standard was not being used.			

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
Lynette Lewis	Administrator/Director of Nursing	8/30/2024 11:11:33 AM