STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157541	A. BUILDING B. WING	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPOINTS HOME HEALTH CARE INC	9801 PRAIRIE AVE, HIGHLAND, IN, 46322

(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: 10/29/24, 10/30/24, 10/31/24 Unduplicated Skilled Census for the Past 12 Months: 71 At this Emergency Preparedness survey, Allpoints Home Health Care, Inc. was found to not be in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	E0000	*At the time of the state survey, AllPoints failed toprovide state Surveyor with the complete Emergency Preparedness binder. Many items had not been included in theEmergency Binder provided to the surveyor. Since survey exit on 10/31/24, the remaining missing information has nowbeen included in the Emergency Preparedness Binder, including individualized emergencyplans for each patient, Emergency Preparedness Policy and Procedures for ourAgency's response to an emergency event.*	
E0001	Establishment of the Emergency Program (EP) 483.73	E0001	**E0001 Establishmentof the Emergency Program (EP) CFR(s): 484.102**	2024-11-22

	§403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:		*At the time of thestate survey, AllPoints failed to provide state Surveyor with complete andupdated Emergency Preparedness Binder and Agency's Policy Binder. Severalupdated items had not been included in the binders. Since survey exit on10/31/24, both Emergency Preparedness Binder and Agency Policy Binder nowcontain compete and updated information. The following are steps taken to address this deficiency and measures put in place so that this deficiency doesnot reoccur.* **(E017)** Effective11/8/2024 new patients have individualized emergency plans completed at thestart of care during the comprehensive assessment, this emergency plan isincluded in the patient's comprehensive assessment. Individualized Emergency Preparedness Planshave also been developed for all existing patients. A copy of patients' emergency plan is placedinside the patient's home folder, uploaded to the patient's electronic medicalrecord, hard copy placed in the patients'	

	Based on record review and interview, the agency failed to include individual patient emergency plans in the comprehensive assessment (E017), failed to include in the policy and procedures the process for informing state and local officials of on-duty staff and patients that are unable to be reached (E019), failed to include in the policy and procedures the method of follow up with on-duty staff and patients to determine services that are needed due to the interruption of services in an emergency, nor how to contact state/local officials of on-duty staff and patients that are unable to be reached (E021), failed to include a system for documentation that preserves patient information, protects patient confidentiality, and secures and maintains the availability of records(E023), failed to evidence a policy which includes the use of volunteers and process for emergency staffing (E024), failed to evidence the communication plan had been reviewed with in the last 2 years (E029), failed to include a communication plan that included the contact information for patients, all staff, entities providing services under arrangement, physicians (E030), and state and federal emergency preparedness officials (E031), failed to evidence an alternate means of communication with staff and federal/state/regional/local emergency officials (E032), failed to evidence a method of sharing information medical documentation for patients under the agency's care with other health care providers to maintain continuity of care, and in the event of an evacuation, a means of releasing patient information and providing general information about the general condition and location of the patients under the agency's care (E033), and failed to address how the agency will share necessary information with the authority (E034). The findings include: The emergency preparedness plan (EP) failed to evidence inclusion of individual patient emergency plans in the comprehensive assessment for all active patients. The EP failed to include in the policy and procedures the process for informing state and local officials of on-duty staff and patients that are unable to be reached nor include in the policy and		paper chart and final copy in theAgency's Emergency Preparedness Binder. ***This deficiency has beenaddressed and corrected as of 11/22/2024*** ***How deficiency has beencorrected:*** Administrator in-service all clinicalstaff on 11/8/24 on Agency's Emergency Preparedness Policy and proceduresincluding the requirement that individualized emergency plans must be made atthe start of care and be included in the patient's comprehensive medicalassessment record. Emergency Plan to also include patient-specific evacuationneeds, mobility status, and medication management, Emergency contactinformation (minimum one contact per patient). Individualized EmergencyPreparedness Plans have been reviewed with each active patient and theircaregivers by patient's RN case manager. A copy of patients' emergency plans has beenplaced inside each	

	procedures the method of follow up with on-duty staff and patients to determine services that are needed due to the interruption of services in an emergency, or how to contact state/local officials of on-duty staff and patients that are unable to be reached. The EP failed to include a system for documentation that preserves patient information, protects patient confidentiality, and secures and maintains the availability of records. The EP failed to evidence a policy which includes the use of volunteers and process for emergency staffing or evidence the communication plan had been reviewed with in the last 2 years. The EP failed to include a communication plan that included the contact information for patients, all staff, entities providing services under arrangement, physicians, and state and federal emergency preparedness officials. The EP failed to evidence an alternate means of communication with staff and federal/state/regional/local emergency officials, nor a method of sharing information medical documentation for patients under the agency's care with other health care providers to maintain continuity of care, and in the event of an evacuation, a means of releasing patient information and providing general information about the general condition and location of the patients under the agency's care. The EP failed to address how the agency will share necessary information with the authority. On 10/31/24 at 4:00 pm, the Administrator indicated the policies and documentation were not included in the emergency preparedness plan and they did not know where they were.		patient's home folder, uploaded to the patient's electronicmedical record, hard copy placed in the patients' paper chart and final copy inthe Agency's Emergency Preparedness Binder. ***How recurrence will beprevented:*** Emergency PreparednessCommittee will review the emergency plan quarterly, conduct annual drills toensure readiness. TheQA Team will be responsible for the ongoing monitoring of this deficiency,reviewing each active patient's comprehensive assessment for completeindividualized emergency plans. ***Responsible parties:*** Administrator will be responsible for ensuring this deficiencydoes not reoccur. **(E019)** Since surveyor exit on 10/31/24, we haveincluded in our Emergency Preparedness Plan, our Agency's Policy for EmergencyPreparedness that includes "Specific Response Instructions" which detailsinstructions to be followed in the event of an emergency: Including the phonenumbers to contact the state, local and Federal emergency management officialswith contact information of patients and staff that were	

			Agency. ***This deficiency has been corrected as of 11/22/2024*** ***How this deficiency has been corrected:*** Administrator in-serviced all staff on 11/8/2024 of Agency'sPolicy for Disaster/Emergency Preparedness. All staff received copy of agency's policy including EmergencyPreparedness Response Plan with SpecificResponse Instructions which includes the contact information for state, localand federal emergency management officials. ***How recurrence will be prevented:*** The Administrator will be responsible for the ongoingmonitoring of this deficiency and review annually agency's emergencypreparedness plan and policies as it relates to specific response instructions. ***Responsible Party:*** Director of Nursing will be	

			responsible for ensuring thisdeficiency does not reoccur. **(E021)** Agency's Emergency Preparedness Plan andAgency's Policy for Emergency Preparedness has been updated to include"Specific Response Instruction" which provides detailed instructions to befollowed in the event of an emergency*: included are instructions as how to follow up with on duty staff andpatients to determine services that are needed due to any interruption ofservices during an emergency.* ***This deficiency has been addressed and corrected as of11/22/2024*** *How deficiency has been corrected:* Administrator in-serviced all staff on 11/8/2024 regardingAgency's Policy #A-230 Emergency Preparedness. All staff received copy of agency's Disaster/Emergency Preparednesspolicy and a copy agency's Emergency Preparedness Response Plan which includesthe specific	

			instructions as how to follow up with on duty staff and patientsto determine services that are needed due to any interruption of servicesduring an emergency instructions as to how to contact on-duty staff andpatients during an emergency. ***How recurrence will be prevented:*** The Administrator will be responsible for the ongoingmonitoring of this deficiency and review annually agency's emergencypreparedness plan and policies. ***Responsible Party:*** Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur. **(E023)** Agency'sEmergency Preparedness Policy #A-265 has been reviewed and included in theagency's policy book that is located in a designated place inside theoffice. This policy includesinstructions to insure	

			patient clinical information will be maintained byAgency and kept confidential, with procedures in place, in the event of an emergency,to preserve patient information, protect patients' confidentiality, and securesand maintains the availability of patient's medical records. Patient's medicalrecords are maintained in serval forms, Electronic Medical Record (EMR) alsosaved in the "Cloud storage" which can be accessed from any location, patientmedical records also maintained on a USB thumb drive kept off-site in a securedlocation, Hard Copy record kept on site at the office in a locked room and tobe transported to the Administrator/ Emergency Coordinators home in the eventof an emergency. Agency's Administrator designated a specific place for Agency'sPolicy & Procedure Binder and Agency's Emergency Preparedness Binder, whichis currently located in a central location within the office for staff andstate surveyors to have access to.	

			This deficiency has been corrected as of 11/22/2024 ***How deficiency has been corrected:*** Administrator in-serviced all staff on 11/8/2024 regardingpolicy and procedures to preserve patient information, protect patients'confidentiality, and secure and maintain the availability of patient's medicalrecords in the event of an emergency. All staff notified of the new location of Agency's Policy Binder andEmergency Preparedness Binder. ***How reoccurrence will be prevented:*** The Administrator will be responsible for the ongoingmonitoring and review of agency's policy and procedures related emergencypreparedness to preserve patient information, protect patients'confidentiality, and secures and maintains the availability of patient'smedical records. ***Responsible Party:*** Director of Nursing will be responsible for ensuring	

			thisdeficiency does not reoccur. **(E024)** Agency updated its Emergency Policy andProcedures have been developed to include the use of volunteers and the processfor emergency staffing. **This deficiency has been corrected as of 11/22/2024** ***How the deficiency was resolved:*** This deficiency has been addressed at the board meeting on11/20/24 and Policy for Volunteers was created ***How reoccurrence will be prevented:*** ***A***dministrator will review and update theEmergency Preparedness Policy annually as it relates to the use of volunteers ***Responsible party:***	

			The Administrator will be responsible for the ongoingmonitoring and annual review of agency's policy and procedures related toemergency preparedness and as it related to the use of volunteers. **(E029)** Emergency Preparedness Policy has previously been reviewed 10/7/2024 andrevised 11/22/24. This policy includes acommunication plan between staff, patients, physicians, state, local andfederal emergency officials, hospitals etc. Indicates alternate means of communication via email, electronic EMR,wireless devices/cellphones, local radio station AM1230 WJOB. Emergency Response Procedure includes thetelephone numbers of staff, patients, physicians, state, local and federalemergency officials, local hospitals. **This deficiency has been corrected as of 11/22/2024** ***How deficiency has been corrected:*** Administrator in-serviced all	

			regardingAgency's Emergency Preparedness Policy. All staff received copy of agency's Emergency Preparedness policy and acopy agency's Emergency Preparedness Response Plan which includes acommunication plan between staff, patients, physicians, state, local andfederal emergency officials, hospitals, and instructions how to contact on-dutystaff and patients during an emergency. ***How reoccurrence will be prevented:*** The Administrator will be responsible for the ongoingmonitoring and review of agency's policy and procedures related tocommunication procedures included in agency's emergency preparedness plan. ***Responsible Party:*** Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur. **(E030)** Since surveyor exit on 10/31/2024, EmergencyPreparedness Binder	

			includes a communication plancontaining contact information including telephone numbers for patients, allstaff, physicians, and all other entities providing services to all activepatients. **This deficiency has been corrected as of 11/22/2024** ***How this deficiency has been corrected:*** Administrator in-serviced all staff on 11/8/2024 regardingAgency's Emergency Preparedness Policy regarding agency's communication plan. All staff received copy of agency's EmergencyPreparedness policy and a copy agency's Emergency Preparedness Response Planwhich includes a communication plan containing contact information includingtelephone numbers for patients, all staff, physicians, and all other entitiesproviding services to all active patients. ***How reoccurrence will be prevented:*** The Administrator will be responsible for the ongoingmonitoring and review	

			of agency's policy and procedures related tocommunication procedures included in agency's emergency preparedness plan. ***Responsible Party:*** Director of Nursing will be responsible for ensuring this deficiencydoes not reoccur. **(E031)** Emergency Preparedness Binder and ResponsePlan has been updated to includes agency's communication plan containing the contactinformation with telephone numbers for state and federal emergency preparednessofficials. **This deficiency has been corrected as of 11/22/2024** ***How deficiency has been corrected:*** Administrator in-serviced all staff on 11/8/2024 regardingAgency's Emergency Preparedness Policy and Emergency Response regardingcommunication plan. All staff receivedcopy of agency's Emergency Preparedness policy and a copy agency's	

			EmergencyPreparedness Response Plan which includes a communication plan containingcontact information including telephone numbers for state and federal emergencypreparedness officials. ***How reoccurrence will be prevented:*** The Administrator will be responsible for the ongoingmonitoring and review of agency's policy and procedures related tocommunication procedures included in agency's emergency preparedness plan. ***Responsible Party:*** Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur. **(E032)** Emergency Preparedness Binder and ResponsePlan now includes *Agency's alternate means of communication to communicatewith state, local, regional and federal emergency officials.* Agency to communicate via telephone	

			landline,if services are available, or via email, fax, electronic EMR, wirelessdevices/cellphones, local radio station AM1230 WJOB. **This deficiency has been corrected as of 11/22/2024** ***How this deficiency has been corrected:*** Administratorin-serviced all staff on 11/8/2024 regarding Agency's Emergency PreparednessPolicy and Emergency Response regarding *alternatemeans of communication*. All staffreceived copy of agency's Emergency Preparedness policy and a copy agency'sEmergency Preparedness Response Plan which includes alternate forms ofcommunication including the contact information for state, local, regional andfederal emergency preparedness officials. Staff will be trained at leastannually on emergency preparedness. Agency will conduct semi-annual drills toensure readiness or document actual emergencies when the emergency plan hasbeen activated to include an	

			evaluation of how the process worked. -specificplans now include: • Information-sharing proceduresunder 45 CFR 164.510(b)(4) to maintain continuity of care while adhering toHIPAA regulations. • Evacuation procedures andnotifications to state and local emergency preparedness officials, tailored toeach patient's medical needs and home environment. ***How reoccurrence will be prevented:*** The Administrator will be responsible for the ongoingtraining of staff; and the monitoring and review of agency's policy andprocedures related to alternate means of communication in the event of anemergency. QA Team will audit quarterly to ensure compliance.Emergency Preparedness Plan will be reviewed and updated annually. ***Responsible Party:***	

			Administrator will be responsible for ensuring thisdeficiency does not reoccur. **(E033)** Emergency Preparedness Policy Includes *methods of sharing information andmedical documentation for patients under the agency's care with other healthcare providers to maintain continuity of care, in the event of an emergency ormandatory evacuation, and a means of releasing patient information andproviding general information about the condition and location of the patientsunder agency's care*. According to state regulations, patient's medicalinformation may be transferred with patient's written consent, to state &local officials, other home health care providers, local hospitals, or nursinghomes in the event of an emergency. This agency has several methods in place to transferpatient's medical information: via fax (if available), verbally over the phone(if phone services are not interrupted), electronic EMR, via	

			by hard copy/paper record. Patient's individualized plan ofcare will be provided to other medical providers (hospitals, nursing homes,physicians) who will be providing services in the event of an emergency. ***This deficiency has been addressed and corrected as of11/22/2024*** ***How deficiency has been corrected:*** Administrator in-serviced all staff on 11/8/2024 regardingAgency's Emergency Preparedness Policy and Emergency Response regarding methodsof sharing information and medical documentation for patients. ***How reoccurrence will be prevented:*** The Administrator will be responsible for the ongoingmonitoring and review of agency's policy and procedures related to *methodsof sharing information and medical documentation for patients under theagency's care with other health care providers to maintain continuity of care,in the event of an emergency or*	

			mandatory evacuation. ***Responsible Party:*** Administrator will be responsible for ensuring thisdeficiency does not reoccur. **E034)** Emergency Preparedness Policy Includes *methods of sharing medical informationand documentation to local authorities for patients under the agency's care inthe event of an emergency. Providing general information about the conditionand location of the patients under agency's care. According to stateregulations, patient's medical information may be transferred with patient'swritten consent, to state & local officials in the event of an emergency.* Pertinent patient information is includedon patient's emergency preparedness plan that is located inside Agency's Folderand left at each patient's home. This Agency has updated theirconsent form to include a box that will give the Agency permission to shareinformation including medical documentation for patients under the agency'scare in the event of an evacuation. We	

			have updated our policy to include aprocess to release patient information about the general condition and locationof patients under our care. This agency has several methods in place to transferpatient's information and medical records: via fax (if available), verballyover the phone (if phone services are not interrupted), electronic EMR, viaemail (if internet is available) or by hard copy/paper record. ***This deficiency has been addressed and corrected as of11/22/2024*** ***How deficiency has been corrected:*** Administrator in-serviced all staff on 11/8/2024 regardingAgency's Emergency Preparedness and Emergency Response regarding methods ofsharing medical information and documentation to local authorities for patientsunder the agency's care in the event of an emergency. **This deficiency has been corrected as of 11/22/2024**	

			The Administrator will be responsible for the ongoingmonitoring and review of agency's policy and procedures related to methods ofsharing patient information with local authorities in the event of an emergency. ***Responsible Party:*** Administrator will be responsible for ensuring thisdeficiency does not reoccur.	
G0000	INITIAL COMMENTS This was a Post-Condition revisit for a home health recertification survey conducted on 9/20/2024. Survey Dates: 10/29/2024-10/31/2024 Unduplicated Skilled Admissions for the last 12 Months: 71 During the Post Condition revisit survey, six Conditions of Participation were determined to be back into compliance at 42 CFR 484.55 Comprehensive Assessment of Patients, 484.58 Discharge Planning, §484.65 Quality Assessment	G0000		

	/Performance Improvement, 484.70 Infection Prevention and Control, and 484.105 Organization and Administration of Services. Ten [10] standard level deficiencies were determined to be back in compliance, eight [8] standard level deficiencies were recited, and one [1] new standard level deficiency was determined to be non-compliant. Based on the Condition-level deficiencies during the 9/20/2024 survey, Allpoints Home Health Care Inc. was subject to an fully extended survey, pursuant to section 1891(c)(2)(D) of the Social Security Act, on 9/20/2024. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating a home health aide training, skills competency and/or competency evaluation program for a period of two years beginning 9/20/2024 and continuing through 9/19/2026. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QA: 11/12/2024			

G0520	5 calendar days after start of care 484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on record review and interview the agency failed to evidence the comprehensive assessment was completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care for 1 of 2 patients with a start of care date of 10/24/24 (Patient 13). The findings Include: On 10/29/24, the record for Patient 13 indicated a skilled nurse visit was conducted on 10/24/24 and a comprehensive assessment was initiated at that visit for the start of care. The record failed to evidence the comprehensive assessment was completed.	G0520	**G0520 Five (5) calendar days "after" start of careCFR(s): 484.55(b)(1)** Patient #13 was admitted to AllPoints Home Health lateafternoon on 10/24/2024, nurse case manager performed initial assessment andcompleted comprehensive assessment Oasis which was signed/submitted on10/29/24, which was the 5th calendar day "after" start of care. This occurreddue to misunderstanding the wording of "5 days after start of care. **This deficiency has been addressed and corrected as of11/22/2024** ***How this deficiency has been corrected:*** Administrator In-serviced all clinical staff on 11/8/24,immediately post survey exit to discuss the "5 calendar day after start ofcare" requirement as per the state surveyor's clarification of this rule.Comprehensive assessment must be completed in a timely manner, consistent withthe patient's immediate needs, but	2024-11-22

	During an interview on 10/31/24 beginning at 11:30 a.m., the Clinical Manager (CM) indicated they did not complete the assessment because they believed they had more time to complete the comprehensive assessment.		no later than 5 calendar days after thestart of care. ***How recurrence will be prevented:*** QA team will be responsible for the ongoing monitoring ofthis deficiency to ensure comprehensive Oasis are completed in 5 calendar days. ***Responsible Party:*** Administrator will be responsible for ensuring thisdeficiency does not reoccur.	
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: (1) The patient's current health, psychosocial, functional, and cognitive status; Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessment included a complete physical assessment in 2 of 2 clinical records reviewed with a comprehensive assessment since the date of correction of 10/20/2024. (Patient #10, 13)	G0528	**G0528 Health, psychosocial, functional, cognition CFR(s):484.55(c)(1)** Comprehensive assessment must accurately reflect thepatient's status, and must include, at a minimum, patient's current healthstatus, psychosocial, functional, and cognitive status. 1. a.) Patient#10 was admitted to Agency on 10/24/2024, initial assessment wascompleted by skilled nurse at which point there was no indication that patienthad difficulty swallowing. Clinical	2024-11-22

	The findings include: On 10/29/24, the comprehensive assessment for Patient 13, dated 10/24/24 indicated the patient to take 17 units of levemir (an injectable medication used for the treatment of diabetes) in the morning and the evening. On 10/30/24, the comprehensive assessment dated 10/24/24 indicated the patient to take 16 units of levemir in the morning and the evening. The comprehensive assessment dated 10/24/24 included a gastrointestinal assessment indicating the patient's last bowel movement was 10/20/24. The record further indicated the patient had abnormal stool/constipation. The record failed to evidence interventions performed. During an interview on 10/31/24 beginning at 11:30 a.m., the Clinical Manager (CM) indicated that they forgot to reconcile that medication with the Patient 13 caregiver during the visit for start of care and used ordered dosage for the medication from a previous		referral documentation received from Rehabreferral facility did not indicate a diagnosis for Dysphagia, nor had homespeech therapy been ordered. Medical doctor from Rehab referral facilityindicated on Page 15 of referral, that patient was "*Independent withswallowing" and "Modified independent with cognition*" On Friday, October25, 2024 after office hours, Agency received a fax for ordersfrom Rehab referral facility for patient #10 to receive occupational and speechtherapy services. On the morning, of Monday, October 28, 2024 patient and hiswife, were informed of the referral for OT/ST services, but patient's wifeadamantly and aggressively refused both OT and ST services for patient.Patient's wife indicated on multiple occasions that she is a retired RegisteredNurse/ and POA for patient and is capable of exercising patient's upper body sothere is no need for OT services and that there was no evident need for speechtherapy services. On October 30, 2024 when the state surveyor observed patientcoughing after taking a sip of his beverage, the state surveyor later indicatedto	

	they text the patient's wife to clarify the dose and made the medication change in the record prior to completing the document on 10/29/24. The CM indicated there was no documentation on the assessment for interventions related to the constipation found during the comprehensive assessment. 1. During an observation of care at the home of Patient #10 on 10/30/2024, at 1:07 PM, the patient was observed coughing after sipping water while reclined in bed. A drainage bag was observed with clear, dark yellow fluid hanging on the side of the bed a plastic tube running from the bag to under the patient’s gown. The clinical record review evidenced a referral document from Entity 9 which indicated a progress note from the speech therapist dated 10/21/2024 which indicated the patient had dysphagia (difficulty swallowing) and exhibited signs and symptoms of aspiration (food, liquid, or other substance enters the airway and eventually the lungs by accident).		office clinical manager that patient should be assessed by a speechtherapist. Patient’s wife was made aware of the surveyor’s observation andrecommendation. After which, skilled nurse thoroughly reviewed a copy of theSpeech therapy progress notes received from the Rehab facility and encouragedpatient and patient’s wife of the benefits of both speech and occupationaltherapies. After which patient and his wife agreed to receive ST and OTservices. SN notified patient’s PCP of patient’s decision, and since thenorders for OT and ST services were received and these therapy services arecurrently being provided. ***This deficiency addressed and corrected 11/22/2024*** ***How thedeficiency has been corrected:*** This deficiency has been addressedand resolved on 11/6/24. SN notified patient’s PCP of patient’s decision toreceive OT and ST services, and since then orders for OT and ST services werereceived 11/6/2024, these therapy	

	The start of care comprehensive assessment dated 10/24/2024 and completed by Registered Nurse (RN) 1 failed to evidence the assessment included the patient's swallowing ability and risk of aspiration. The comprehensive assessment indicated the patient had a foley catheter (a plastic tube inserted into the bladder and held in place with an inflated balloon to drain urine from the bladder). The comprehensive assessment failed to evidence the size of foley catheter and the inflated balloon. On 10/31/2024, at 12:28 PM, RN 1 indicated she did not document the size of the foley catheter and the balloon on the comprehensive assessment and indicated she did not assess the patient's dysphagia and aspiration precautions. 2. On 10/29/24, the comprehensive assessment for Patient 13, dated 10/24/24 indicated the patient to take 17 units of levemir (an injectable medication used for the treatment of diabetes) in the morning and the evening. On 10/30/24, the comprehensive assessment dated 10/24/24		services are currently being provided. Administrator In-serviced Clinicians 11/8/24 of the need to thoroughly review and address anyrecommendation noted in the clinical documentation received from referringprovider. That Comprehensive assessment must accurately reflect the patient'sstatus, and must include, at a minimum, patient's current health status,psychosocial, functional, and cognitive status.*How recurrence will beprevented:* QA Team and Clinical Manager areresponsible for the ongoing continuous monitoring of this deficiency, bythoroughly reviewing initial referral clinical documentation on every patientto ensure comprehensive assessment accurately reflects patient's status. Oversees daily assessment accuracy. Weekly QA audits of all new assessments for six monthsuntil 100% accuracy achieved. ***Responsible Party:*** Director of Nursing will beresponsible for ensuring compliance that this deficiency	

	indicated the patient to take 16 units of levemir in the morning and the evening. The comprehensive assessment dated 10/24/24 included a gastrointestinal assessment indicating the patient's last bowel movement was 10/20/24. The record further indicated the patient had abnormal stool/constipation. The record failed to evidence interventions performed. During an interview on 10/31/24 beginning at 11:30 a.m., the Clinical Manager (CM) indicated that they forgot to reconcile that medication with the Patient 13 caregiver during the visit for start of care and used ordered dosage for the medication from a previous admission. The CM indicated they text the patient's wife to clarify the dose and made the medication change in the record prior to completing the document on 10/29/24. The CM indicated there was no documentation on the assessment for interventions related to the constipation found during the comprehensive assessment.		does not reoccur. b.) Patient #10 has a Foley catheter in placeupon admission. On the Initial comprehensive oasis, SN indicated under thesection "Interventions".. "*Using aseptic technique, SN to insert #16 Fr-10cc catheter to gravity drainage system q month and as needed for occlusion,dislodgement or malfunction of catheter*". This intervention followed overto the patient's Plan of Care and was available in the patient's home at thetime of surveyors on site visit. **This deficiency has beenaddressed and corrected as of 11/22/2024** ***How deficiency is resolved:*** Patient's comprehensive Oasisassessment and plan of care includes Foley catheter interventions Administrator in-serviced clinicalstaff on 11/8/2024 regarding comprehensive assessment must accurately reflectthe patient's status, note if catheter present, size/type/balloon size	

	410 IAC 17-14-1(a)(1)(A)		andfrequency when need to be changed and must include, at a minimum, patient'scurrent health status, psychosocial, functional, and cognitive status. ***How reoccurrence will beprevented:*** QA Team and Clinical Manager areresponsible for the ongoing continuous monitoring of this deficiency, bythoroughly reviewing initial referral clinical documentation on every patientto ensure comprehensive assessment accurately reflects patient's status for sixmonths until 100% accuracy achieved. ***Responsible Party:*** Director of Nursing will beresponsible for ensuring this deficiency does not reoccur. 2.) Regarding Patient #13 medication reconciliation.The initial comprehensive assessment that the state surveyor observed had notbeen completed or signed by the clinician and did not reflect the correct doseof insulin. Clinical manager indicated that the insulin was not present withthe patient's medications at the	

			verified withpatient's wife the correct dose of insulin that patient is receiving, after whichCM updated the medication profile to reflect the correct dose of 16 units dailyin the morning, CM then signed and submitted the comprehensive Oasis at 7pm onOctober 29, 2024, and the Plan of Care signed by patient's physician reflectsthe correct medication and dosage. **This deficiency has beenaddressed and corrected on 10/29/24.** ***How deficiency is resolved:*** Medication profile was reconciledwith patient's physician and patient's wife and reflects correct dosage forinsulin Administrator In-serviced clinicalstaff on 11/8/24 regarding timely and accurate documentation, medications mustbe reconciled with patient's physician on the day of admission, and be accuratelyreflected on the comprehensive assessment.	

			How reoccurrence will beprevented: QA Team and Administrator areresponsible for the ongoing continuous monitoring of this deficiency, bythoroughly reviewing initial referral clinical documentation on every newpatient for medication accuracy. ***Responsible Party:*** Administrator will be responsiblefor ensuring this deficiency does not reoccur. Regarding Patient #13, constipation interventions,located under "interventions" *its noted that SN to perform bowel program onetime a week, using rectal suppository and digital stimulation, for the removalof stool SN to teach and train patient's wife to perform bowel program."* ***This deficiency has beenaddressed and corrected on 10/30/2024*** ***How deficiency wascorrected:*** Physician order received and	

			patient'schart now reflects *SN to perform bowel program one time a week, using rectalsuppository and digital stimulation, for the removal of stool, SN to teach andtrain patient's wife to perform bowel program: with measurable goalof 1 to 2 bowel movements per week amounting to 2 cups of stool per week*. Administrator in-serviced clinicalstaff on 11/8/2024 and re-educated on S.M.A.R.T. documentation of patientspecific measurable goals and outcomes. ***How recurrence will beprevented:*** QA Team and Administrator areresponsible for the ongoing continuous monitoring of this deficiency, bythoroughly reviewing clinical documentation on every patient, and re-educateclinicians on S.M.A.R.T. goals with measurable outcomes. ***Responsible party:***	

			Administrator will be responsiblefor ensuring this deficiency does not reoccur.	
G0530	Strengths, goals, and care preferences 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on record review and interview the agency failed to evidence the comprehensive assessment reflected the patient's The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's	G0530	**G0530 Strengths, goals, andcare preferences CFR(c)(2): 484.55(c)(2)** Regarding Patient #13, thecomprehensive assessment did not reflect patient specific goals with measurableoutcomes for patient's constipation diagnosis ***This deficiency has beenaddressed and corrected on 10/30/2024***	2024-11-22

	progress toward achievement of the goals identified by the patient		***How deficiency wascorrected:*** Verbal order received frompatient's physician on 10/30/24, patient's chart updated to reflect "*SN toperform bowel program one time a week, using rectal suppository and digitalstimulation, for the removal of stool, SN to teach and train patient's wife toperform bowel program: with measurable goal of 1 to 2 bowel movementsper week amounting to 2 cups of stool per week*." Administrator in-serviced clinicalstaff on 11/8/2024 educating allclinicians on measurable goals to assure that they are Specific, Measurable,Attainable, Relevant, and Time-bound (SMART). Patient #13 has had his goalupdated to include 1 to 2 bowel movements per week amounting to 2 cupsof stool per week. ***How recurrence will beprevented:*** QA Team and Administrator areresponsible for the ongoing continuous monitoring of this deficiency, by thereview clinical	

	and the measurable outcomes identified by the home health		specific goals with measurableoutcomes. QA Team to perform quarterlyaudits 12 months until 100% accuracy is achieved. ***Responsible party:*** Administrator will be responsiblefor ensuring this deficiency does not reoccur.	

	agency for 1 of 2 patients with a start of care date of 10/24/24			

	(Patient 13). The Findings Include: The record reviewed on 10/29/24 included a comprehensive assessment dated 10/24/24 for Patient 13 which included a gastrointestinal assessment indicating the patient's last bowel movement was 10/20/24. The record further indicated the patient had abnormal stool/constipation. The record failed to evidence measurable outcomes for bowel movements were identified by the home health agency. During an interview on 10/31/24 beginning at 11:30 am			

	indicated the physician had instructed the CM on 10/30/24 the Patient 13 should have approximately 2 cups of stool per week, but there is no documentation.			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review, and interview, the agency failed to ensure all medications were reviewed for potential adverse effects and drug reactions in 2 of 2 active clinical records reviewed with a comprehensive assessment after the date of correction of 10/20/2024. (Patient #10, 13) The findings include: The record reviewed on 10/29/24 for patient 13 included a comprehensive assessment dated 10/24/24 indicated medications were reconciled with no issues found	G0536	**G0536 A Review of all currentmedications CFR(s): 484.55(c)(5)** ***1.*** Patient #10 during a home visit with thestate surveyor, it was observed that patient had “lidocaine plus cream” on thebedside table that was not included in the initial assessment performed byskilled nurse on 10/24/2024. During the initial assessment patient’s wifeprovided skilled nurse with ALL the medications that the patient was currentlytaking. Lidocaine was not ordered by patient’s physician, nor was it providedto the nurse at the initial SOC assessment. Patient is not using Lidocaine.State surveyor also observed patient’s wife administer a Tramadol pill topatient. Upon questioning, patient’s wife informed skilled nurse that she hadgiven patient one of her own prescribed pain	2024-11-22

	during review. The electronic record activity log reviewed on 10/31/24 for Patient 13, indicated medications were added on 10/26/24. All medications were deleted on 10/29/24 and re-entered on 10/29/24 and 10/30/24. During an interview on 10/31/24 beginning at 11:30 a.m., the clinical manager (CM) indicated they had reconciled the medications in the home at the start of care on 10/24/24, however they had forgotten to add levemir (an injectable medication used to treat diabetes) and miralax (a medication used to regulate bowel movements), the CM indicated when they entered the medications in the electronic health record, the record only included the two medications, forcing the CM to discontinue all medications and re-enter them. During an observation of care at the home of Patient #10 on 10/30/2024, beginning at 12:15 PM, a tube labeled "lidocaine plus cream" (a topical medication used to treat pain)		pills because patient was havingpain. ***This deficiency has beenaddressed and corrected on 10/30/24*** ***How the deficiency beingcorrected:*** SN notified patient's Physicianof patient's wife being observed administering her personal prescription ofTramadol to patient. The same day Nurse Practitioner from PCP office made homevisit and prescribed patient his own prescription of Tramadol for his pain.Patient's chart/medication profile updated to reflect all current medications. Clinical staff in-serviced on 11/8/24regarding proper review and reconciliation of all medications with thepatient's ordering physician on admission. Clinicians re-educated of the importanceto reconcile patient's medications at each visit. Clinicians instructed to question patients or patients'caregivers regarding any over the counter medications that are observed inpatient's home that are not noted on patient's medication	

	was observed on the bedside table. The patient was moaning and grimacing while attempting to sit on the side of the bed with the assistance of Physical Therapist (PT) 3. The patient's caregiver asked the patient if they wanted Tramadol (a controlled pain medication) to which the patient answered yes. The caregiver was observed handing the patient a pill which the patient swallowed. On 10/30/2024, at 12:52 PM, the patient's caregiver indicated the patient used the lidocaine cream every other day for back pain and had used the medication for months. A clinical record review for Patient #10 evidenced a medication profile for the initial certification period of 10/24/2024-12/22/2024 which indicated the medications included acetaminophen (to relive pain and/or fever) and warfarin (a blood thinner to prevent/treat blood clots). The drug-to-drug interactions dated 10/30/2024 indicated a moderate drug interaction between acetaminophen and warfarin. The medication profile		profile received frompatient's physician. ***How reoccurrence will beprevented:*** QA team responsible for theongoing monitoring of this deficiency performing weekly audits of all activepatients' medication profiles including ongoing reconciliation with medicationlist provided by patient's physician to ensure accuracy. Assigned Clinicianwill reconcile patient's medications every visit ***Responsible Party:*** Administrator will be responsiblefor ensuring this deficiency does not reoccur. Pt#10 Comprehensive assessmentdated 10/24/24 failed to evident the assessment included the drug to druginteractions acetaminophen and warfarin ***This deficiency has beenaddressed and corrected on 10/30/24***	

	lidocaine cream and failed to evidence the Tramadol and lidocaine cream had been reviewed for adverse side effects and drug interactions. The start of care comprehensive assessment dated 10/24/2024 and completed by Registered Nurse (RN) 1 failed to evidence the assessment included the drug interaction between acetaminophen and warfarin. On 10/30/2024, beginning at 4:04 PM, the Clinical Manager indicated the comprehensive assessment did not indicate the drug interaction between acetaminophen and warfarin. On 10/31/2024, beginning at 12:28 PM, RN 1 indicated she did not review the lidocaine or the Tramadol. 410 IAC 17-14-1(a)(1)(B)		***How deficiency beingcorrected:*** Clinical staff in-serviced on11/8/24 regarding proper review and reconciliation of all medications with thepatient's ordering physician on admission and assess for drug to druginteractions in order to identify any potential adverse effects, includingineffective drug therapy, duplicate drug therapy and/or non-compliance to drugtherapy. Clinicians instructed that all drug to drug interactions must bedocumented in comprehensive assessment, if not enough space available to list allthe drug to drug interactions, report can be printed and faxed to physician. ***How reoccurrence will beprevented:*** QA team responsible for theongoing monitoring of this deficiency performing weekly audits and "drug todrug" assessment of all active patients' medication profiles to ensure accuracy. ***Responsible Party:*** Administrator will be	

			responsiblefor ensuring this deficiency does not reoccur. 2. Regarding Patient #13 medication reconciliation.Clinical Manager indicated medications were reconciled with no issues at thetime of assessment, and clinician performed drug to drug interaction review inthe software while she was charting at her home and was able to see the drug todrug interaction report without printing it. On Monday October 28, 2024, clinicalmanager attempted to print the drug to drug interaction report but could notdue to the medications suddenly were no longer in the software formularyformat. Clinical manager had to delete and re-enter each medication again inorder for them to be included in the software formulary format. This occurredas a result of an Axxess software update. ***This deficiency has beenaddressed and corrected on 11/8/2024***	

			How the deficiency beingcorrected: The issue has been resolved withthe software company since the state survey exit. All medications on thepatient's medication profile are accurate and drug to drug interactions havebeen assessed and documented, the Plan of Care reflects correct medications andhas been signed by patient's physician. Administrator in-serviced clinicalstaff 11/8/24 regarding proper review and reconciliation of all medicationswith the patient's ordering physician on admission, and assess for drug to druginteractions in order to identify any potential adverse effects, includingineffective drug therapy, duplicate drug therapy and/or non-compliance to drugtherapy. Drug to drug interactions must be documented in the comprehensiveassessment at start of care. ***How reoccurrence will beprevented:*** QA team responsible for theongoing monitoring of this deficiency performing weekly	

			audits and "drug todrug" assessment of all active patients' medication profiles to ensureaccuracy. ***Responsible Party:*** Director of Nursing will beresponsible for ensuring this deficiency does not reoccur.	
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 observation, record review, and interview, the agency failed to ensure services were provided as directed in the plan of care in 3 of 3 active clinical records reviewed (Patient #3, 10, and 13) The findings include: On 10/29/24, the record for	G0572	**G0572 Plan of care CFR(s): 484.60(a)(1)** 1. State surveyor observation of care for patient#10 during visit at the patient's home, surveyor observed patient grimacing asthe physical therapist was assisting patient to sit on the side of his hospitalbed. PT failed to perform painassessment this visit. ***This deficiency has been addressed and corrected on11/22/2024*** ***How the deficiency is being corrected:*** Administrator in-serviced allclinicians including therapist on 11/22/2024, regarding the need to assesspatients' pain, for severity, frequency, duration	2024-11-22

	comprehensive assessment and start of care dated 10/24/24. The record failed to evidence a plan of care, nor orders for the provision of services for the established start of care date. During an interview on 10/31/24 beginning at 11:30 a.m., the clinical manager indicated they had not completed the comprehensive assessment until 10/29/24, therefore the plan of care could not be generated for Patient 13 because the comprehensive assessment was not complete. 1. A clinical record review for Patient #10 evidenced a plan of care for the initial certification period 10/24/2024-12/22/2024 which indicated the physical therapist (PT) was to assess the patient's pain management. During an observation of care at the patient's home on 10/30/2024, beginning at 12:15 PM, the patient was observed to be alert, oriented, and verbal. PT 3 was observed assisting the patient to sit on the side of the bed, and the patient was observed moaning and grimacing. The patient's caregiver asked the patient if		and characteristic of thepain and the effectiveness of the pain management each visit and to call thephysician for any changes in patients' condition or values outside orderedparameters. Instructed clinicians on proper documentation regarding painassessments. In addition, all clinicians instructed on the need to assesspatient's vital signs each visit and notify physician and nurse case manager ofany abnormal findings or values outside ordered parameters. ***How reoccurrence will be prevented:*** QA Team and Administrator is responsible for the ongoingmonitoring of this deficiency, reviewing all clinician visit notes daily foraccurate documentation regarding pain assessments ***Responsible Party***: Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur. 2. Discharged patient #3 during state surveyorreview of patient's clinical record, it was	

	they wanted Tramadol (a controlled pain medication) to which the patient said yes. The caregiver was observed handing the patient a pill which the patient swallowed. PT 3 was not observed to assess the patient's pain management to include the severity, frequency, duration, and characteristics of the pain, and the effectiveness of the pain management. On 10/30/2024, at 1:16 PM, PT 3 indicated the patient was in pain and was assessed by the grimacing, guarding, body language, and verbal complaints. PT 3 indicated she did not obtain the patient's severity, frequency, duration, and characteristics of the pain. 2. A clinical record review of Patient #3 evidenced a plan of care for an initial certification period 9/5/2024-11/3/2024 which indicated the agency was to notify the physician for a heart rate greater than 120 beats per minute (bpm). The nurse visit note dated 10/21/2024 and completed by Registered Nurse (RN) 1 indicated the patient's heart rate was 134 bpm and failed to		on10/21/24 SN visit was 134 bpm with activity, and on 10/21/24 PT visit it wasnoted that patient's heart rate was 126 bpm with activity. There was no need tocall and notify physician of patient's elevated heart rate for either visit ***This deficiency has beenaddressed and resolved based on signed physician order dated 10/11/24*** ***How the deficiency is beingcorrected:*** According to the signed PhysicianOrder dated 10/11/24 which states "to only call physician if temp is less than96 degrees or greater than 101.8F; and resting heart rate greater than 126 bpmand heart rate with activity of greater than 145 bpm" Administrator In-serviced allclinicians on 11/22/24 re-educated ofthe need to assess patient's vital signs each visit and notify physician and nursecase manager of any abnormal findings or values outside ordered parameters. Allclinicians have been educated on the need to	

	evidence the physician was notified. The PT visit note dated 10/21/2024 and completed by PT 3 indicated the patient's heart rate was 126 bpm and failed to evidence the physician was notified. On 10/30/2024, at 2:44 PM, PT 3 indicated she did not notify the physician of the elevated heart rate. On 10/31/2024, at 12:54 PM, RN 1 indicated she did not notify the physician of the elevated heart rate. 410 IAC 17-13-1(a)		onthe plan of care. PT3 has had individualized instruction on the need to assessand document patient's pain to include severity, frequency, duration andcharacteristics of the pain. RN1 and PT3 have had individualized education onthe need to contact the physician for any vital signs including pulse rateoutside of the ordered parameters. Allclinicians have been educated on the need to develop the plan of careimmediately after the admission or to at least create the physician's order forthe provision of services immediately after speaking with the physician orhis/her representative. ***How reoccurrence will be prevented:*** QA Team and Administrator is responsible for the ongoingmonitoring of this deficiency, reviewing all clinician visit notes daily foraccurate documentation regarding pain assessments. ***Responsible Party:*** Administrator will be	

			responsible for ensuring thisdeficiency does not reoccur. 3. Patient #13 during the state survey clinical review ofpatient's medical records was noted that the Plan of Care had not beengenerated at that time because the comprehensive assessment Oasis had not beenfinalized and signed. Patient #13 was admitted to the Agency lateafternoon on 10/24/2024, nurse case manager performed initial assessment andcompleted comprehensive assessment Oasis which was signed/submitted on10/29/24, (which was the 5th calendar day "after" start of care), at whichpoint the "plan of care" was generated and available and placed in thepatient's home folder prior to state surveyor visit on 10/30/24. **This deficiency has been addressed and corrected as of11/22/2024** ***How this deficiency has been corrected:*** Administrator In-serviced all clinical staff on 11/8/24,immediately post survey exit to discuss the "5	

			calendar day after start ofcare" requirement as per the state surveyor's clarification of this rule.Comprehensive assessment must be completed in a timely manner, consistent withthe patient's immediate needs, but no later than 5 calendar days after thestart of care. ***How recurrence will be prevented:*** QA team will be responsible for the ongoing monitoring ofthis deficiency to ensure comprehensive Oasis are completed in 5 calendar days. ***Responsible Party:*** Administrator will be responsible for ensuring thisdeficiency does not reoccur.	
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	G0574	**G0574 Plan of care must include the following CFR(s):484.60(a)(2)(i-xvi)** **Agency failed to evidence the plan of care wasindividualized to the needs of patient to include the pertinent diagnosis, medications,treatments,**	2024-11-22

	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. Based on observation, record review, and interview, the agency failed to evidence the plan of care was individualized to the needs of the patient to include the medications, treatments, measurable goals, and medical equipment in 3 of 3 active clinical records reviewed. (Patient #3, 10, 13) The findings include: A document provided by the		**measurable goals, and medical equipment.** 1. Patient #10 during a home visit with the statesurveyor, it was observed that patient had “lidocaine plus cream” on thebedside table that was not included in the initial assessment performed byskilled nurse on 10/24/2024. During the initial assessment patient’s wifeprovided skilled nurse with ALL the medications that the patient was currentlytaking. Lidocaine was not ordered by patient’s physician, nor was it present atthe initial SOC assessment. After state surveyor observed Lidocaine in thepatients home, SN questioned patient’s wife regarding the Lidocaine, patient’swife stated that she was using Lidocaine cream on patient months ago, prior tothis recent hospitalization/SNF stay.	

	Office Manager on 10/30/24; who indicated the document was the plan of care for Patient 13 completed by the clinical manager on 10/29/24, included an intervention for finger stick blood glucose checks to be completed by the skilled nurse during every skilled nurse visit. During a home visit observation for Patient 13 on 10/30/24 beginning at 1:00 pm, the skilled nurse/clinical manager asked the patient's caregiver about the patient's blood sugars. The caregiver indicated they had been out of testing strips for a couple of days and blood sugars had not been performed. The clinical manager indicated to the caregiver they would pick up test strips from the patient's pharmacy. The clinical manager did not perform a finger stick blood glucose test during the home visit. During an interview on 10/31/24 beginning at 11:30 a.m., the clinical manager indicated they had not picked up the test strips from the pharmacy, indicating Patient 13 caregiver picked them up that morning. The clinical manager		State surveyor also observedpatient's wife administer a Tramadol pill to patient. Patient's wife informedskilled nurse that she had given patient one of her own prescribed Tramadol painpills, because patient was having pain. ***This deficiency has beenaddressed and corrected on 10/30/2024*** ***How the deficiency beingcorrected:*** SN notified patient's Physician on10/30/24 of patient's wife being observed administering her personalprescription of Tramadol to patient. Onthe same day, 10/30/24, the Nurse Practitioner from PCP office made home visit forfollow up post hospitalization, and prescribed patient his own prescription ofTramadol for his pain. Orders received and patient's chart/medication profileupdated to reflect current medications including Tramadol. Administrator In-serviced Clinicianson 11/8/24 the plan of care must be individualized to the needs of patient toinclude	

	indicated they had not notified the physician they were unable to perform the finger stick blood glucose monitoring during the visit on 10/30/24. Based on observation, record review, and interview, the agency failed to evidence the plan of care was individualized to the needs of the patient to include the medications, treatments, measurable goals, and medical equipment in 1 of 3 active clinical records reviewed. (Patient #3, 10) The findings include: 1. During an observation of care at the home of Patient #10 on 10/30/2024, beginning at 12:15 PM, the patient was observed coughing after sipping water through a straw while reclined in bed. A tube labeled "lidocaine plus cream" (a topical medication used to treat pain) was observed on the bedside table, and the caregiver was observed handing the patient a pill identified by the caregiver as Tramadol (a controlled pain medicatiaon) which the patient swallowed.		the pertinent diagnosis, medications, treatments, and measurable goals. ***How reoccurrence will beprevented:*** QA team responsible for theongoing monitoring of this deficiency performing weekly audits of all activepatients' medication profiles including ongoing reconciliation with medicationlist provided by patient's physician to ensure accuracy. Assigned Clinicianwill reconcile patient's medications every visit. ***Responsible Party:*** Administrator will be responsiblefor ensuring this deficiency does not reoccur. Patient #10 was admitted to the Agency on 10/24/2024, initial assessment was completed byskilled nurse there was no indication that patient had difficulty swallowing.Clinical referral documentation received from Referring Rehab facility did notindicate a diagnosis for "Dysphagia", nor was speech therapy services ordered. Physician from "Referring Rehab facility"indicated on Page 15 of	

	On 10/30/2024, at 12:52 PM, the patient's caregiver indicated the patient used the lidocaine cream every other day for back pain and had used the medication for months. A clinical record review evidenced a referral document from Entity 9 which included a progress note from the speech therapist dated 10/21/2024 which indicated the patient had dysphagia (difficulty swallowing) and exhibited signs and symptoms of aspiration (food, liquid, or other substance enters the airway and eventually the lungs by accident). The speech therapist recommended thin liquids by spoon only, medication crushed or whole in puree, and a double swallow with all intake. The plan of care for the initial certification period of 10/24/2024-12/22/2024 signed by Registered Nurse (RN) 1 failed to evidence the diagnosis of dysphagia, aspiration precautions, and the recommendations of thin liquids by spoon only, medication crushed or whole in puree, and a double swallow		referral documentation, that patient was *"Independentwith swallowing" and "Modified independent with cognition*". On Friday, October 25, 2024 afteroffice hours, Agency received a fax for orders from ReferringRehab facility for patient #10 to receive occupational and speech therapyservices. On Monday, October 28, 2024 patient and his wife, were informed ofthe referral for OT/ST services, but patient's wife adamantly and aggressivelyrefused both OT and ST services for patient. Patient's wife indicated onmultiple occasions that she is a retired Registered Nurse/ and POA for patientand is capable of exercising patient's upper body and that there was no needfor speech therapy services. On October 30, 2024 when thestate surveyor observed patient coughing after taking a sip of his beverage,the state surveyor later indicated to office clinical manager that patientshould be assessed by a speech therapist. Patient's wife was made aware of	

	indicated the patient's medications included warfarin (a blood thinner to treat/prevent blood clots and required monitoring by a blood test, PT/INR). The plan of care failed to evidence the frequency of and who was monitoring the PT/INR. The plan of care indicated the goals included the patient was to have optimal effectiveness of pain management and failed to ensure the goal was measurable and individualized to indicate the patient's optimal level of pain management. On 10/30/2024, beginning at 12:15 PM, the patient's caregiver indicated they monitored the PT/INR by a machine at home which electronically sent the result to the physician. The patient's caregiver indicated they checked the PT/INR weekly. On 10/31/2024, beginning at 12:28 PM, RN 1 indicated she did not include the ST recommendations and aspiration precautions on the plan of care, because she was not aware of the ST recommendations. RN 1 indicated she did not include		recommendation. After which, skilled nursethoroughly reviewed with patient and patient's wife a copy of the ST therapyprogress notes received from the referring rehab facility, at which pointpatient and patient's wife were agreeable for patient to receive ST and OTservices. ***This deficiency has beenaddressed and corrected as of 11/22/2024*** ***How this deficiency has beencorrected:*** SN notified patient's physician ofpatient being agreeable to received ST and OT services. Orders received from patient'sphysician on 11/6/2024, patient's plan of care currently reflects updated information,services are currently being provided. Administrator In-servicedClinicians 11/8/24 regarding of the need to thoroughly review and address anyrecommendation noted in the clinical documentation received from referringprovider. That Comprehensive assessment must accurately	

	the lidocaine cream, Tramadol, and the monitoring of the warfarin on the plan of care. RN 1 indicated the plan of care did not include an individualized and measurable goal related to the patient's pain. 2. A clinical record review for Patient #3 evidenced a plan of care for the initial certification period of 9/5/2024-11/3/2024 signed by RN 1 a referral document from Entity 1 dated 8/30/2024 which indicated the patient's primary diagnosis was metastatic basal cell carcinoma of the skin (skin cancer that has spread to other parts of the body) and included additional diagnoses of low back pain and metastasis to bone. The plan of care indicated the patient had a neoplastic (tumor) wound to the abdomen requiring dressing changes daily. The plan of care failed to evidence the goals included an individualized and measurable goal related to pain.		must include, at a minimum, patient's current health status,psychosocial, functional, and cognitive status.*How recurrence will beprevented:* QA Team and Clinical Manager areresponsible for the ongoing continuous monitoring of this deficiency, bythoroughly reviewing initial referral clinical documentation on every patientto ensure the plan of care accurately reflects patient's complete medicalcondition. Administrator to perform weekly audits ofall new start of care assessments until 100% accuracy is achieved. ***Responsible Party:*** Director of Nursing will beresponsible for ensuring compliance that this deficiency does not reoccur. Patient #10 regarding PT/INRmanagement. Patient's home physician has been managing patient's PT/INR andwarfarin doses for years prior to patient's recent hospitalization. Patient'swife who is a retired registered nurse checks patient's PT/INR levels weeklyand coordinates directly with patient's physician in	

	On 10/31/2024, at 12:54 PM, RN 1 indicated the goal related to pain was not very clear on the plan of care and should have included the patient's pain would be 7 or less on a scale of 0-10. 410 IAC 17-13-1(a)(1)(D)(iii, v, viii, ix, x, xiii)		managing patient'swarfarin therapy and will continue to do so. ***This deficiency has beenaddressed and corrected on 11/22/2024*** ***How deficiency wascorrected:*** It is noted on page 18 of the Comprehensiveassessment Oasis that "Patient's wife, who is a former nurse, monitorspatient's INR at home with a PT/INR machine". PT/INR results sent directly tophysician, patient's wife coordinates directly with patient's physician office.SN verified this information with patient's physician for accuracy regardingcaregiver management of warfarin therapy including the weekly monitoring of patient'sPT/INR levels. Order obtained and plan of care updated to reflect thisinformation. Administrator in-serviced allclinicians on 11/8/24 re-educated of the requirement that patient's plan ofcare must be individualized with patient specific interventions, goals withmeasurable outcomes; the need to follow the orders on	

			the plan of care or toobtain new orders if indicated. Clinicians re-educated on the need to includeall supplies used for patient care and to obtain an order for their use.Clinicians instructed on the need to include frequency and duration ofservices, patient specific interventions, education and measurable goalsidentified during the comprehensive assessment on all patients. RN1 has had individualized educationon the need to include all medications and safety precautions recommended byreferral sources. RN1 was also given individualized education on the need toinclude the order for any PT/INRs ordered for patients on Coumadin/Warfarin. *How recurrence will be prevented:* QA Team andClinical Manager are responsible for the ongoing continuous monitoring of thisdeficiency, by thoroughly reviewing initial referral clinical documentation onevery patient to ensure comprehensive assessment accurately reflects patient'smedical status including any lab orders and	

			who is responsible for obtaining labs.QA team will perform quarterly audits to assure continued compliance. ***Responsible Party:*** Administrator will be responsible for ensuring compliancethat this deficiency does not reoccur. Patient #10 during a home visitwith the state surveyor on 10/30/2024, it was observed by state surveyor thatpatient had “lidocaine plus cream” on the bedside table that was not includedin the initial assessment performed by skilled nurse on 10/24/2024. During theinitial assessment patient’s wife provided skilled nurse with ALL themedications that the patient was currently taking. Lidocaine was not ordered bypatient’s physician, nor was it provided to SN at the initial comprehensiveassessment. Patient’s wife later informed skilled nurse that she was usingLidocaine cream on patient months ago, prior to this recent hospitalization/SNFstay. State surveyor also observed patient’s	

			topatient. SN questioned patient's wife on 10/30/2024, patient's wife informedskilled nurse that she had given patient one of her own prescribed Tramadol painpills, because patient was having pain. ***This deficiency has been addressed and corrected on 10/30/2024*** ***How the deficiency is being corrected:*** Administrator in-serviced allclinicians including therapist on 11/22/2024, regarding the need to assesspatients' pain, for severity, frequency, duration and characteristic of thepain and the effectiveness of the pain management each visit and to call thephysician for any changes in patients' condition or values outside orderedparameters. Instructed clinicians on proper documentation regarding painassessments. In addition, all clinicians instructed on the need to assesspatient's vital signs each visit and notify physician and nurse case manager ofany abnormal findings or values outside ordered parameters. ***How reoccurrence will be***	

			prevented: QA Team and Administrator is responsible for the ongoingmonitoring of this deficiency, reviewing all clinician visit notes daily foraccurate documentation regarding pain assessments. QA team willperform quarterly audits to assure continued compliance. ***Responsible Party***: Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur. 2. During medical record review by state surveyor,it was noted that patient's plan of care failed to clearly identify patient'sgoals for pain management. Unfortunately, patient was in denial of herterminal diagnosis and need for Palliative Care and Hospice Services. Doctor was fully aware of patient's constantpain, patient with unattainable goals due to terminal condition and on themaximum dose of pain medication. ***This deficiency has been addressed;however, this particular deficiency was unable to be corrected due to***	

			patienthas passed away. ***How the deficiency is beingcorrected:*** Administrator In-services all clinicianson 11/8/2024, regarding the individualized patient Plan of Care must reflect specificinterventions with measurable goals as it relates to patient's pain, with painbeing assessed for severity, frequency, duration and characteristic of the painand the effectiveness of the pain management each visit and to call thephysician for any changes in patients' condition or values outside orderedparameters. Instructed clinicians on proper documentation regarding painassessments. RN1 was also given individualized education on SMART goals.RN1 was also given individualized education that if an intervention cannot beperformed at a visit per order, then she needs to contact the physician tonotify of the reason why. ***How reoccurrence will be prevented:*** QA Team and clinical manager willaudit all SOC's to ensure	

			disciplines, measurable goalsand outcomes as it relates to patient's pain, discipline frequencies, medications,and to ensure that all necessary physician orders have been completed andsigned by patient's physician. ***Responsible party:*** Director of Nursing will beresponsible for ensuring this deficiency does not reoccur. Patient #13, during the statesurveyor home visit on 10/30/2024, SN was observed attempting to checkpatient's blood glucose level, however patient was out of test strips andlancets. Skilled nurse offered to go purchase these supplies for patient, butpatient's wife insisted that she would get them. ***This deficiency wasaddressed and corrected 10/31/2024*** ***How the deficiency has beencorrected:*** On the following morning 10/31/2024SN followed up with patient's wife via text, patient's wife stated shepurchased the	

			patient's random blood sugar lastnight, and results were within normal ranges. Administrator in-serviced all clinicianson 11/22/24 and contracted staff on 11/25/24 that they must immediately notify patient'sphysician who is following patients' care, anytime a new prescription isrequired for medical supplies, including whenever supplies or DME are notpresent in patient's home ***How reoccurrence will be prevented:*** QA Team and Clinical Manager will reviewall clinician visit notes for accuracy to ensure documentation is completed forwhen new prescriptions are required for medical supplies, including wheneversupplies or DME are not present in patient's home and all necessary physicianorders are complete. ***Responsible party:*** Director of Nursing will beresponsible for ensuring this deficiency does not reoccur.	
G0590	Promptly alert relevant physician of changes	G0590	**G0590 Promptly alert relevantphysician of changes**	2024-11-22

	484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to notify the physician of changes in patient's condition or a need to change the plan of care in 1 of 1 active clinical records reviewed with referrals for occupational therapy (OT) and speech therapy (ST). (Patient #10) The findings include: A clinical record review for Patient #10 (start of care 10/24/2024) evidenced a referral document from Entity 9 which included a progress note from the speech therapist dated 10/21/2024 which indicated Patient had dysphagia (difficulty swallowing) and exhibited signs and symptoms of aspiration (food, liquid, or other substance enters the airway and eventually the lungs by accident). The speech therapist recommended thin liquids by spoon only, medication crushed or whole in puree, double swallow with all intake, and home health ST. The		**CFR(s): 484.60 (c)(1)** Patient #10 regarding statesurveyor review of physician order date 10/28/2024 had been completed by SNindicating the patient's refusal of OT and ST services but had not yet beensigned by patient's physician. ***Thisdeficiency has been addressed and corrected on 10/30/2024*** ***How the deficiency beingcorrected:*** Verbal Order was created by SN on10/28/2024 document faxed to physician on 10/29/2024. Signedverbal order fax was received from physician on 10/30/2024 but at the time of statesurvey it had not been uploaded to the patient's EMR. AdministratorIn-serviced Clinicians on 11/8/24 and contracted staff on 11/25/24 that theymust immediately notify all relevant physicians, who are following patients'care, of any changes in patients' condition and complete verbal order the sameday. Allclinicians	

	progress note from the occupational therapist dated 10/21/2024 indicated Patient had a decrease in activities of daily living, balance, upper extremity strength and endurance, functional transfers, and safety. The OT recommended home health OT. Review failed to evidence the agency provided OT and ST services. A communication note completed by OT 1 and dated 10/28/2024 indicated Patient's wife refused OT services. An agency document titled "Physician Order" dated 10/28/2024 and completed by RN 1 indicated Patient refused OT and ST services; the document was not signed by the physician. On 10/30/2024, at 2:51 PM, OT 1 indicated she did not notify the physician of Patient's refusal of OT services. On 10/31/2024, beginning at 12:28 PM, RN 1 indicated she did not call the physician responsible for the plan of care to inform him of the OT and ST recommendations and Patient declined services. RN 1		have been educated on the need to contact the physician of anychanges in patients condition or a need to revise the plan of care. OT1 and RN1have both been given individualized instruction on the need to contact thephysician for any refusal of services or need for services that may not havebeen ordered initially. RN1 has additionally been re-educated on the need toreview all referral information before or during an admission to make sure allinformation given by the referral source is addressed. Administrator instructed officemanager that all signed and completed documents must be uploaded to patients'EMR upon receipt. ***How reoccurrence will beprevented:*** QA Team and Clinical Manager areresponsible for the ongoing continuous monitoring of this deficiency, byreviewing each physician order ensuring that each order has been sent tophysician on time, received back signed in a timely manner and uploaded on theday it was received.	

	indicated she was not aware of the ST swallow recommendations. On 10/3/2024, at 3:52 PM, the Clinical Manager indicated the agency did not talk to the physician or physician's representative of Patient decline of OT and ST recommendations. 410 IAC 17-13-1(a)(2)		***Responsible Party:*** Administratorwill be responsible for ensuring this deficiency does not reoccur.	
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on observation, record review, and interview, the agency failed to coordinate care in 2 of 2 active clinical records reviewed with home health aide (HHA) services. (Patient #10, 13) The findings include: The record reviewed on 10/29/24 for Patient 13 included a physician order signed 10/22/24 for a hoyer lift. During an observation on	G0606	**G0606 Integrate allservices CFR(s): 484.60(d)(3)** 1. Patient#10 - During state surveyor observation visit, HHA began shaving patient's facewith an electric razor, but was unable to effectively remove the hairs fromaround patient's mouth, patient's wife insisted that HHA use the blade razorthat patient's wife provided. While HHA was using the blade razor, she nickedpatient's upper lip causing him to bleed. HHA cleaned patient's lip and appliedpressure and then had patient apply pressure until bleeding had stopped. HHAwaited until the bleeding stopped before leaving the patient's home. The homehealth	2024-11-22

	10/30/24, with the physical therapist and again with the skilled nurse/clinical manager, a hoyer lift was not observed in the home for Patient 13. During an interview on 10/31/24 beginning 11:30 am, the clinical manager indicated the physician informed the clinical manager Patient 13 would need a hoyer lift when discussing the patient for referral. The clinical manager indicated they have been in communication with the durable medical equipment company, but the company has not delivered the hoyer lift. The clinical manager indicated they had not notified the provider that the hoyer lift had not arrived for Patient 13. 1.During an observation of care at the home of Patient #10 on 10/30/2024, at 1:26 PM, HHA 2 was observed shaving the patient's neck and upper lip with a disposable razor when the upper lip was noted with bright red blood. HHA 2 was observed wiping the blood and then holding a paper towel against the upper lip. HHA 2 indicated she nicked the patient while shaving. The patient		aide did not immediately notify patient's nurse case manager. She waiteduntil she was finished seeing patients, and then reported the incident tooffice clinical manager, and then to patient's nurse case manager. ***Deficiency has beenaddressed and corrected 11/22/2024*** ***How the deficiency hasbeen corrected:*** Administratorin-serviced nurses and HHA staff 11/8/24 of agency deficiency related tocoordination of care between nurses and home health aides. Nurses re-educatedof the need to coordinate care with each discipline providing services to theirpatients and address any specific needs of that patient. HHAs instructed on theneed to review the HHA Care Plan prior to each visit, reviewing all notedprecautions. Agency has educated all clinicianson the need to notify the RN Case Manager and Clinical Director of any changesin patients' condition or incidents. HHA2 has been given individualizededucation on the need to notify the RN case manager of any problems	

	continued to bleed and HHA 2 was observed wiping the blood on the upper lip and instructing the patient to hold the paper towel between his lips until HHA 2 left the home at 2:04 PM. A clinical record review indicated a plan of care for the initial certification period of 10/24/2024-12/22/2024 which indicated the patient's medications included warfarin (a blood thinner used to treat/prevent blood clots) and indicated the safety measures included bleeding precautions. The home health aide note dated 10/30/2022 completed by HHA 2 indicated HHA 2 nicked the patient during shaving and failed to evidence the HHA notified the nurse case manager. On 10/30/2024, at 4:16 PM, the Clinical Manager indicated HHA 2 should not have used a disposable razor for shaving due to the patient's bleeding precautions and indicated HHA 2 did not notify the agency that she nicked the patient causing him to bleed during the shave.		during avisit and on what the meaning of bleeding precautions. She has been instructedto never use a disposable razor on a patient with bleeding precautions. ***How recurrence will be prevented:*** Clinical Manager is responsible for the ongoing monitoringof this deficiency to assure continued compliance. ***Responsible Party:*** Administrator will beresponsible for ensuring this deficiency does not reoccur. 2. Patient#13 During state surveyor visit on 10/30/24 it was observed that a hoyer wasordered but not present in patient's home. Verbal order was receivedby patient's physician on 10/23/24, in which CM typed up order and faxed to patient's physician forsignature, and the signed copy was faxed to DME provider, each day SNreached out to DME provider to check status of hoyer. DME provider was coordinating with patient's	

			insurance provide forauthorization in order to fill this order. Patient's physician was aware of this delaybecause DME provider had been in contact with the physician to get additional informationregarding medical necessity. SN documented this information in a communication note. ***This deficiency wasaddressed and corrected 11/22/2024*** ***How the deficiency hasbeen corrected:*** Patient has received the Hoyer from DME provider on 11/6/2024 Administratorin-serviced all clinicians on 11/22/24 and contracted staff on 11/25/24 of the need tocontact the physician if there is a delay in the delivery of any needed DME.	

			Physician must be immediatelynotified anytime a new prescription is required for medical supplies, includingwhenever supplies or DME are not present in patient's home and documentation ofthat communication. ***How reoccurrence will be prevented:*** QA Team and Clinical Managerwill review all clinician visit notes for accuracy to ensure documentation iscompleted for when new prescriptions are required for medical supplies,including whenever supplies or DME are not present in patient's home and allnecessary physician orders and communication notes have been completed. ***Responsible party:*** Director of Nursing willbe responsible for ensuring this deficiency does not reoccur.	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention.	G0682	**G0682Infection Prevention CFR(s):484.70(a)** Comprehensivecorrective action plan developed for each identified deficiency,	2024-11-22

	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 observation, record review, and interview, the agency failed to ensure all employees practiced standard/universal precautions to prevent the transmission of infections and failed to follow agency infection control policies and procedures in 2 of 2 home visits. (#10, 13) The findings include: During a home visit observation for Patient 13 on 10/30/24 beginning at 11:00 a.m., Physical Therapist 3 (PT 3) was observed to have removed a thermometer from the clinician bag and obtain the patient's temperature. PT 3 wiped the thermometer with a sanitizing wipe and immediately placed into a plastic zip storage bag. PT 3 removed a blood pressure cuff from the clinician bag and obtain blood pressure from the left arm. PT 3 then moved the blood pressure cuff to the right arm and obtain another blood pressure reading. The PT wiped the blood pressure cuff with the sanitizing wipe and immediately placed into a plastic zip storage bag. PT 3 removed exercise		implementedstaff re-training programs for Infection Control and Prevention AdministratorIn-serviced Nurses, therapist and HomeHealth Aides, regarding company policies: Standard Precautions and BagTechnique. Staff re-educated on Infection control and Prevention, proper handhygiene, Bag Technique. 1. Duringthe surveyor review of the “Home health policy for standard precautions” thepolicy states clinicians should wash their hands with soap and water afterremoving their gloves. This policy had been revised on October 25, 2024, whichnow includes under the heading “Hand Washing”: *Hands should be washed beforeand after patient contact. Wash hands during patient care if hands becomesoiled. Wash hands with soap and water or use alcohol-based hand sanitizerimmediately after removing gloves*. Inadvertently, the state surveyorreviewed the old policy from 12/20/2016 and not the updated revised copy. ***This deficiency was addressed and corrected on 11/22/2024***	

	bands from clinician bag, performed exercises with the patient, wiped with sanitizing wipe and immediately put bands in the plastic zip bag. PT 3 repeated this process for all exercise equipment. During a home visit observation for Patient 13 on 10/30/24 beginning at 1:00 pm, the skilled nurse/clinical manager removed a blood pressure cuff from the clinician bag, obtained a blood pressure reading from the patient, wiped the blood pressure cuff with a sanitizing wipe and immediately placed the blood pressure cuff into a plastic zip bag. During an interview on 10/31/24 beginning at 11:30 a.m., the clinical manager indicated the sanitizing wipes had a disinfectant time of 15 seconds, therefore she did not see the need to allow for dry time of the equipment before placing in the plastic zip bag. 1. Review of a policy revised		***How the deficiency is being corrected:*** Agencyhas revised their Standard Precautions for Home Care Policy to include the useof alcohol-based hand sanitizer may also be used after removing gloves. Agencyhas also revised their Bag Technique policy to include the use of alcohol-basedhand sanitizer may be used before replacing equipment in the bag and neverre-enter bag unless hands have been cleaned with hand sanitizer or hand washingif visibly soiled. Administrator in-serviced all fieldstaff on 11/22/2024 re-educated field staff regarding company policy for "StandardPrecautions." All staff have been educated onthese revised policies. ***How reoccurrence will be prevented:*** Administrator will perform monthly home visits for two quarters to observe field staff providing patient care to ensure company policies are being followed regarding "Proper hand washing" and quality and safe care provided until 100%	

	12/12/2016 titled "Standard Precautions for Home Care" indicated clinicians should wash their hands with soap and water after removing gloves. 2. Review of a policy revised 12/20/2016 titled "Bag Technique" indicated after cleaning the used equipment, clinicians should wash their hands before replacing equipment in the bag and should never re-enter the bag unless the clinicians washed their hands. 3. During an observation of care at the home of Patient #10 on 10/30/2024, beginning at 12:15 PM, Physical Therapist (PT) 3 was observed taking the patient's vital signs using a blood pressure cuff and pulse oximeter (a medical device to determine the percentage of oxygen in the blood and heart rate) obtained from PT 3's bag. PT 3 wiped the blood pressure cuff and pulse oximeter with wipes and returned immediately to PT 3's bag. The canister the wipes were removed from indicated surfaces were to be wiped until wet and then were to dry for 4 minutes. PT 3 failed		compliance is achieved. All staff to be in-serviced on standard precautions annually and upon hire. ***Responsible Party:*** Clinical Manager is responsible for the ongoing monitoring of this deficiency to assure compliance. 2. Duringthe surveyor review of the "Home health policy for Bag Technique" inadvertently,the state surveyor reviewed the old policy from 12/20/2016, not the currentpolicy from 1/9/2024. ***This deficiency was addressed and corrected on 11/22/2024*** ***How the deficiency is being corrected:*** Agencyhas also revised their Bag Technique policy on 11/6/2024 to include the use ofalcohol-based hand sanitizer may be used before replacing equipment in the bagand never re-enter bag unless hands have been cleaned with hand sanitizer orhand washing if visibly soiled. Administratorin-serviced all	

	and pulse oximeter to dry per the instructions of the sanitizing wipes. PT 3 failed to perform hand hygiene after the removal of gloves. PT 3 was observed entering the main compartment of the bag to retrieve a plastic bag containing soap and paper towels without performing hand hygiene prior to entering the bag. On 10/30/2024, at 1:16 PM, PT 3 indicated the dry time after sanitizing equipment was "2 seconds" and hand hygiene was to be performed when entering and leaving the patient's home. On 10/30/2024, at 4:10 PM, the Administrator indicated staff should perform hand hygiene after removing gloves and before entering the visit bag. 410 IAC 17-12-1(m)		staff on 11/22/2024 of Agency's revised Policy regarding "BagTechnique" all field staff reviewed revised policy. Staff instructed on theneed to review the dry times for the kind of wipes they are using to clean usedequipment to make sure they are waiting the appropriate time prior to placingthe equipment back in their bag. *Clinical Staff performed return demonstrationsof proper bag technique.* ***How reoccurrencewill be prevented:*** Administratorwill perform monthly home visits for two quarters to observe field staffproviding patient care to ensure company policies are being followed regarding "BagTechnique" and quality and safe care provided until 100% compliance isachieved. ***Responsible Party:*** ClinicalManager is responsible for the ongoing monitoring of this deficiency to assurecompliance. 3. PT3was observed by state surveyor on 10/30/2024, performing care on patient	

			#10not following company policy regarding proper hand washing. ***This deficiency was addressed and corrected on 11/22/2024*** ***Howthe deficiency is being corrected:*** Administratorin-serviced all field staff on 11/22/2024 regarding Agency's revised Hand WashingPolicy that states that *Hands should be washed before and after patientcontact. Wash hands during patient care if hands become soiled. Wash hands withsoap and water or use alcohol- based hand sanitizer immediately after removinggloves*. All field staff re-educated regarding company Hand Washing policy. *ThisPolicy was reviewed by all field staff, followed with staff performing returndemonstrations.* ***How reoccurrencewill be prevented:*** Administratorwill perform monthly home visits for two quarters to observe field staffproviding patient care to ensure company policies are being followed regarding	

			properhand washing and quality and safe care provided until 100% compliance isachieved. ***Responsible Party:*** ClinicalManager is responsible for the ongoing monitoring of this deficiency to assurecompliance. 4. SNstaff was observed by state surveyor on 10/30/2024 performing care on patient#13 not following company policy regarding proper bag technique. ***Thisdeficiency was addressed and corrected on 11/22/2024*** ***Howthe deficiency is being corrected:*** Agencyhas revised their Standard Precautions for Home Care Policy to include the useof alcohol-based hand sanitizer may also be used after removing gloves. Agencyhas also revised their Bag Technique policy to include the use of alcohol-basedhand sanitizer may be used before replacing equipment in the bag and neverre-enter bag unless hands	

			sanitizer or hand washingif visibly soiled. Administrator in-serviced all fieldstaff on 11/22/2024 on company revised "Bag Technique Policy." All staffreviewed Agency's revised policy and return demonstrations were correctlyperformed. Allstaff have been further educated on the need to review the dry times for thekind of wipes they are using to clean used equipment to make sure they arewaiting the appropriate time prior to placing the equipment back in their bag. Allstaff will be educated on infection control including bag technique practicesyearly and upon hire. ***How recurrence will be prevented:***	

			Administratorwill perform monthly home visits for two quarters to observe field staffproviding patient care to ensure company policies are being followed regardingbag technique and quality and safe care provided until 100% compliance isachieved. ***Responsible Party:*** ClinicalManager is responsible for the ongoing monitoring of this deficiency to assurecompliance.	
N0000	Initial Comments This visit was for a revisit of a home health State Re-licensure survey conducted on 9/20/2024. Survey dates: 10/29/2024-10/31/2024 12-Month Unduplicated Skilled Admissions: 71 QA: 11/12/2024 A1	N0000		

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
Helena Black	Assistant Administrator	12/9/2024 11:24:43 PM