STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157600	A. BUILDING B. WING	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME HEALTH CARE INC	9006 CLINE AVENUE, 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
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: January 31, 2025, and February 3 - 4 2025 Unduplicated skilled admissions: 124 Abbreviations used in report: Home Health Aide [HHA], Clinical Manager [CM], Registered Nurse [RN], Plan of Care [POC], Start of Care [SOC], Skilled Nurse [SN], Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST), Masters social worker (MSW), Activities of daily living (ADL), Quality Assurance	N0000		

	(QAPI). QR: 02/14/2025			
N0418	Licensure 410 IAC 17-10-1(l) Rule 10 Sec. 1(l) A home health agency may apply to provide a service that was not listed in its application or renewal application by notifying the department in writing of the new service, the date the service is intended to be offered, and all supporting documentation that shows the home health agency is qualified to provide the additional service. This documentation includes, but is not limited to the following: (1) Personnel qualifications and licensing. (2) National criminal history background check from the Indiana Central Repository established by IC 10-13-3-39 (i) and pursuant to IC 16-27-2. (3) Procedures for the supervision of personnel. (4) Contracts between the home health agency and any person offering the new service. In the event the initial information submitted is not sufficient for the department to determine the home health agency's compliance regarding the new service, the department will inform the home health agency of the additional documents required. A home health agency may not offer additional services until it has received approval from the department to do so.	N0418	The Administrator applied to provide SpeechTherapy service as an additional service in May 2020. Agency will re-applyagain by notifying the Indiana State Department of Health in writing of SpeechTherapy service, the date the service is intended to be offered, and allsupporting documentation that shows Alpha Home Health Care, Inc. is qualifiedto provide the additional service. The documents will include a letter on AlphaHome Health Care, Inc.'s letterhead, personnel orientation to the job, a copyof the job-description, resume, a copy of the current license, a current expandedor national criminal history report, procedures for the supervision ofpersonnel, record of physical exam including evaluation of TB, contractsbetween Alpha Home Health Care, Inc. and the speech therapist, signature ofadministrator on the letter, and a copy of CMS-1572. All documentation will bemailed to ISDH/Acute Care Division 2 N Meridian St., Section 4A	2025-03-05

	The agency Form CMS-1572, dated 5/24/22, indicated the services provided by the agency staff included SN, SW, and HHA services, with services under arrangement included OT and PT services. The 1572 indicated the agency did not provide ST services. The personnel record review for ST 1 included a hire date of 5/18/2020. During an interview on 2/3/2025 beginning at 11:45 AM, Administrator relayed the agency began providing ST services in 2020 and she did not inform the state regarding the addition of ST services.		07,Indianapolis, IN 46204 on 3/5/25. The Administrator will follow up with the Departmentfor approval. This deficiency will be corrected by 03/05/2025.	
N0456	Home health agency administration/management 410 IAC 17-12-1(e) Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems.	N0456	On02/27/25 Administration reviewed the Administrator's responsibilities with afocus on an ongoing quality assurance program designed to monitor and evaluatethe quality of patient care, resolve identified problems, and improve patientcare. QAPI meetings are conducted quarterly, within one month after the end ofeach calendar quarter. The QAPI	2025-03-05

	(3) Improve patient care. Based on record review and interviews the agency failed to ensure the administrator was responsible for ongoing quality assurance program designed to monitor and evaluate the quality of patient care, resolve identified problems, and improve patient care. Findings include: The QAPI documentation provided by the agency included the "Quality Assurance Improvement Plan 2024" indicating the governing body and administration were responsible for developing leading and monitoring the QAPI program. The QAPI documentation included QAPI meeting minutes, dated 7/17/2024, conducted by the Administrator to monitor and evaluate the QAPI program. The documentation failed to evidence QAPI was monitored or evaluated since 7/17/2024. The QAPI documents revealed a focus on infection prevention with rates at quarter 1 (January, February, and March) at 29 and quarter 2 (April, May, June) of		program for Quarter 3 of 2024 was monitored andevaluated in a meeting on 10/04/2024; documents were not filed in the QAPIbinder. Post-survey, the QAPI Committee has again reviewed the 2024 3rdquarter report. The Administrator ran patient census reports for all 3 quartersof 2024 and included percentages and average census for all quarters for thefocus area's tracking purposes. The focus on infection prevention was monitoredand evaluated for improvement. In quarter 4 of 2024, Agency had zero activepatients. The QAPI Coordinator conducted an in-service meetingwith Administrator, Alternate Administrator, Alternate Clinical Supervisor,field clinicians and office staff. The in-service included a review of currentQAPI activities from quarter 3: infection prevention, home health error – late recordsubmission, and improvement in bed transferring. The meeting also addressedreasons for and	

	2024 were 21. The QAPI documents included incidents/accident reports reported 6 patient falls in quarter 1 2024 and 2 falls during quarter 2 of 2024. The QAPI tracking did not include percentages nor average census at the time. The QAPI program failed to evidence updated tracking for focus areas since June 30, 2024. The personnel file for Compliance Officer included a job description titled "QAPI Coordinator," signed by Compliance Officer 1/7/2019 that revealed duties to assist CM in the data collection, analysis, acting, and reporting of results in the QAPI program. During an interview on 2/3/2025 at 11:45, the Administrator relayed Compliance Officer oversaw the QAPI program. During a subsequent interview on 2/4/2025 beginning at 10:00 AM, the Administrator revealed the information for QAPI had not been tracked since June of 2024.		importance of quality improvement projects. The QAPI Coordinator continues to assist the ClinicalSupervisor in data collection, analysis, acting, and reporting of results inthe QAPI program. The Administrator continues to monitor, evaluate, and overseeQAPI activities and goals. The QAPI program will be monitored and evaluated atthe end of Quarter 1 of 2025. The Administrator will be responsible for conducting,monitoring , and evaluating the QAPI program quarterly to ensure that the qualityassurance program is ongoing and that these deficiencies are corrected and willnot occur again. This deficiency will be corrected by 03/05/2025.	

N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of an employee's national/expanded criminal history background check pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interviews, the agency failed to ensure personnel records included appropriate job description, qualifications, a copy of a national criminal history, a copy of the current license, nor annual performance evaluations in 7 of 9	N0458	TheAdministrator has reviewed all current direct care and non-direct careemployees' personnel records to ensure documentation of orientation to the joband 1) receipt of job description,2) qualifications, 3) a copy of an employee's national/expanded criminalhistory background check pursuant to IC 16-27-2, 4) a copy of current license,certification, or registration, and 5) annual performance evaluations. The Administrator reviewed licenses of all current directcare employees and verified those expired licenses in https://mylicense.in.gov/everification/. Upon checking, the Administrator obtained and filed acopy of their active current license.	2025-03-05

	(Administrator / CM, Alternate CM, RN 1, RN 3, ST 1, HHA 1, and Compliance Officer). Findings include: 1.The employee list provided, by RN 1 on 2/3/2025 at 10:00 AM, included the name of Compliance Officer with the title of "Compliance." The personnel record for Compliance Officer, date of hire 7/6/2017, failed to evidence a job description for this position, nor an annual performance evaluation since 12/21/2022. During an interview on 2/3/2025 beginning at 11:45 AM, the Administrator revealed Compliance Officer title was "Compliance" and was also in charge of QAPI. 2. The personnel record for Administrator /CM with date of hire 02/28/2014 failed to evidence a current copy of her RN license. The file evidenced the previous with an expiration of 10/31/2023. The personnel file included a limited criminal history report, dated 2/25/2016, and failed to include a national criminal background check. During an interview on		The Administrator checked the HHA state registry ofHHA 1 on 1/29/2024 but did not file a physical copy of the verification in HHA1's personnel file. The digital copy with an expiration date of 1/14/2026 wasprinted and filed as evidence. Upon further review, the personnel file for ComplianceOfficer (hire date: 7/6/2017) contained a signed job description dated 7/6/2017.This document was not noted by the surveyor. The Administrator/Clinical Supervisor conducted annualperformance evaluations on 2/27/2025 for all current direct care and non-directcare personnel. The AlternateAdministrator conducted an evaluation of the Administrator's performance withfocus on noted administrative errors and required compliance and safety issuesregardless of patient census. The Clinical Supervisor conducted a performanceevaluation of the Alternate Clinical Supervisor.	

	2/3/2025 beginning at 11:45 AM, the Administrator relayed the license in her personnel file was expired, the last performance evaluation was in 2022, and there was no national criminal background check. 3. The personnel record for the Alternate CM a hire date of 8/7/2017 and included a copy of her RN license with an expiration date of 10/31/2023 and failed to evidence an active current license. The record failed to evidence an annual performance evaluation since the last evaluation dated 12/8/2022. During an interview, on 2/3/2025 beginning at 11:45 AM, the Administrator relayed the license in her personnel file was expired and the last performance evaluation was in 2022. 4. The personnel record for RN 1, with date of hire 5/15/2023, failed to evidence a copy of their current active RN license, and failed to evidence an annual performance evaluation. During an interview on 2/3/2025 beginning at 11:45 AM, the Administrator relayed		Results and feedback were recorded in thepersonnel files. The next annual performance evaluation is scheduled for December,2025. The Administrator will obtain a copy ofnational/expanded criminal history background check pursuant to IC 16-27-2 forall newly hired direct-care employees prior to first patient contact or notmore than three (3) business days after the date the employee begins to provideservices to a patient. 100% of newly hired employee personnel records will beaudited upon hire for evidence of receipt of job description, qualifications, acopy of an employee's national/expanded criminal history background check, anda copy of current license, certification, or registration. 100% of current employee personnel records will beaudited annually at the end of December for evidence	

	there was not a annual performance evaluation completed yet for RN 1. 5. The personnel record for RN 3 included hire date of 10/11/2016 and a copy of her RN license with an expiration date of 10/31/2023 and failed to evidence an active current RN license. During an interview on 2/3/2025 beginning at 11:45 AM, the Administrator relayed the license in her personnel file expired in 2023. 6. The personnel record for ST 1 with date of hire 5/18/2020, failed to evidence an active current copy of her speech pathologist license, and failed to evidence a performance evaluation since last evaluation dated 12/21/2022. During an interview on 2/3/2025 beginning at 11:45 AM, the Administrator revealed the license in the personnel file for ST 1 expired in 2023 and the last annual evaluation completed for ST 1 was in 2022. 7. The personnel record for HHA 1 with date of hire 11/15/2019, failed to evidence HHA 1 was		annual performanceevaluations. 50% of all direct care personnel records will beaudited quarterly for evidence of 1) receipt of job description, 2) qualifications,3) a copy of an employee's national/expanded criminal history background checkpursuant to IC 16-27-2, 4) a copy of current license, certification, orregistration, and 5) annual performance evaluations. The Administrator will be responsible for monitoringthese corrective actions to ensure that this deficiency is corrected and willnot recur. This deficiency will be corrected by 03/05/2025.	

	active and on the HHA state registry. The file included a copy of their HHA registry with an expiration date of 1/14/2024. During an interview, on 2/3/2025 beginning at 11:45 AM, the Administrator relayed the certification in the personnel chart was not up to date.			
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for	N0464	All directcare personnel records were audited by the Administrator for evidence ofevaluations for tuberculosis and documentations before patient contact andannual TB screening pursuant to CFR(s): 410 IAC 17-12-1(i). Those currentpersonnel who did not have an updated TB risk assessment nor a negativetuberculin skin test nor other testing for the surveillance of TB were askedfor provide a copy of their most recent tuberculin skin test using the Mantouxmethod or a quantiferon-TB assay or one (1) chest radiograph to exclude a diagnosisof tuberculosis in the case of the positive result. Those without any TBevaluations must have a baseline two-step tuberculin	2025-03-05

	tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.		skin test using theMantoux method or a quantiferon-TB assay. The second step of a two-step tuberculin skin test using the Mantouxmethod must be administered one (1) to three (3) weeks after the firsttuberculin skin test was administered. Uponfurther review, ST, hire date: 5/18/2020, provided a negative test result, uponhire, with a baseline two-step tuberculin skin test using the Mantoux method on3/11/20 and 3/13/20. This document was not noted by the surveyor. On2/27/2025, the Administrator in-serviced all current employees having directpatient contact on the requirement of annual TB evaluation and documentation. 100% ofnewly hired direct-care personnel records will be audited by the Administrator within3 days of hire and annually for evidence of TB test	

	Based on record review and interview the agency failed to ensure all employees with direct patient care were evaluated for tuberculosis by a baseline negative two-step tuberculin skin test, and annual screening for tuberculosis in 6 of 7 personnel files reviewed with direct patient contact (Alternate CM, RN 1, RN 3, ST 1, HHA 1, HHA 2). Findings include: 1. The personnel record for RN 1, with date of hire 5/15/2023 and a first patient contact date of 10/27/2023. The medical record included a negative tuberculosis screening with the use of tuberculin, dated 5/8/2023, failed to evidence a two-step negative tuberculin skin test prior to patient contact, nor a prior negative surveillance history. The record failed to evidence an annual testing and screening for tuberculosis since 5/8/2023.		screening. This deficiency will be corrected by 03/05/2025.	

	During an interview on 2/3/2025 beginning at 11:45 AM, the Administrator relayed there was not a two-step negative tuberculosis skin test for RN 1 prior to patient contact and there was not an updated tuberculosis surveillance, testing, nor screening for 2024. 2. The personnel record for the Alternate CM, date of hire 8/7/2017, included an annual tuberculosis risk assessment dated 12/8/2022 and a negative tuberculin skin test dated 12/9/2022. The record failed to include annual screening, testing, nor surveillance for tuberculosis. 3. The personnel record for ST 1, with date of hire, 5/18/2020 failed to evidence a medical personnel file. The agency failed to evidence a two-step negative tuberculin skin test or a negative TB surveillance history before Patient contact. The file failed to evidence an annual screening, risk assessment, nor surveillance for TB. 4. The personnel record for RN 3 failed to evidence annual risk assessment, screening, nor			

	testing for TB since 2020. 5. The personnel record for HHA 1 included a negative tuberculin skin test administered on 10/15/2020. The record failed to evidence a negative tuberculin skin test nor a tuberculosis risk assessment since 10/15/2020. 6. The personnel record for HHA 2 included a negative tuberculin skin test administered on 12/15/2020. The record failed to evidence a negative tuberculin skin test nor a tuberculosis risk assessment since 12/15/2020. 7. During an interview on 2/3/2025 beginning at 11:45 AM, personnel records for the Alternate CM, RN 1, ST 1, HHA 1, and HHA 2 were reviewed with the Administrator who relayed the personnel files did not contain an updated TB risk assessment nor a negative tuberculin skin test nor other testing for the surveillance of TB.			
N0466	Home health agency administration/management 410 IAC 17-12-1(j)	N0466	TheAdministrator reviewed all current personnel records and ensured that physicalexaminations, tuberculosis evaluations and	2025-03-05

	Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on record review and interview the agency failed to ensure the personnel medical files were maintained in separate files and treated as confidential medical records in 2 of 7 personnel files reviewed with direct patient contact (ST 1, RN 3). Findings include: 1.The personnel files for ST 1 included a personnel file and a separate medical personnel file. The personnel file for ST 1 included a physical examination copy dated 4/17/2024 with physical results and a physician's signature. The record failed to keep medical information separate from personnel files. 2. The personnel file for RN 3 included a personnel file and a separate medical personnel file. The personnel file for RN 3 included a medical document of a negative tuberculin skin test.		clinical follow-ups were maintainedin separate medical files and treated as confidential medical records. 100% ofnewly hired personnel records will be audited by the Administrator within 3days of hire to ensure that personnel medical files are maintained in separatefiles and treated as confidential medical records. 50% ofpersonnel records will be audited quarterly for evidence of the medical recordsbeing filed separately. TheAdministrator will be responsible for monitoring this corrective action toensure that this deficiency is corrected and will not recur. This deficiency will be corrected by 03/05/2025.	

	The record failed to evidence the personnel file separate from the medical file. During interview, on 02/04/2025 beginning at 11:45 AM, the Administrator revealed the medical documents were filed in the personnel record in error and should have been filed in the medical personnel files.			
N0472	Q A and performance improvement 410 IAC 17-12-2(a) Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interviews the agency failed to ensure a quality assessment and performance improvement was maintained, with action taken that result in improvement of care, and with he use of objective measures.	N0472	Administration,with QAPI Coordinator, met and reviewed Agency's 2024 QAPI program on 10/4/24.Meeting documents have been filed in the QAPI program binder. Post-survey, the Administrator ran patient censusreports for all 3 quarters of 2024 and included percentages and average censusfor all quarters for the focus area's tracking purposes. The focus on infectionprevention was monitored and evaluated for improvement. With zero activepatients in 2024 Q4, no data was recorded for that period.	2025-03-05

	Findings include: The QAPI documentation provided by the agency included the "Quality Assurance Improvement Plan 2024" indicating the governing body and administration were responsible for developing leading and monitoring the QAPI program. The QAPI documentation revealed QAPI meeting minutes dated 7/17/2024 conducted by the Administrator to monitor and evaluate the QAPI program. The documentation failed to evidence QAPI was monitored or evaluated since 7/17/2024. The QAPI documents revealed a focus on infection prevention with rates at quarter 1 (January, February, and March) at 29 and quarter 2 (April, May, June) of 2024 were 21. The QAPI documents included incidents/accident reports reported 6 patient falls in quarter 1 2024 and 2 falls during quarter 2 of 2024. Tracking did not include percentages nor average census at the time. The QAPI program failed to evidence updated tracking for focus areas since June 30, 2024.		The QAPI Committee met on 2/27/2025 and the Administratorshared the patient census reports and tracking for all 3 quarters of 2024 inorder to evaluate the focus area on infection prevention and plan ongoingactions or steps in reducing infection rates for subsequent quarters. Also, the QAPI Committee monitored andevaluated the 2024 QAPI program and generated a QAPI Plan for 2025. The qualityindicator data collected from selected measures were analyzed, and the problemareas were identified including infection prevention, home health error - recordsubmitted late, and improvement in bed transferring. In-Service meeting withall current staff is scheduled for 03/05/2025. Topics will include the three(3) performance improvement projects: infection control, OASIS submissiondeadline, and patient transfer. Ongoing, the Administrator will be responsible forensuring that the Agency continues to	

	During an interview on 2/4/2025 beginning at 10:00 AM, the Administrator indicated QAPI tracking was completed through June of 2024 and that there was no documentation for the last six months of 2024 nor were problems identified for a QAPI focus in 2025.		develop, implement, maintain, andevaluate a QAPI program that reflects the complexity of the home healthorganization and services. The Administrator will ensure that the Agency takesactions that result in improvements in the agency's performance across thespectrum of care and uses objective measures. This deficiency will be corrected by 03/05/2025.	
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services.	N0488	The Administrator revised and implemented theAgency's discharge policy 9.30.1, "Discharge Criteria and Planning", on02/20/2025. Revision requires notice of discharge of service to the patient,the patient's legal representative, or other individual responsible for thepatient's care at least fifteen (15) calendar days before the services arestopped. The fifteen (15) day period described does not apply in the followingcircumstances: (1) The health, safety, and/or	2025-03-05

	(3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on record review and interview, the agency failed to ensure they developed a policy and implemented to include the required Indiana minimum of 15 calendar days notice of discharge to patients and / or their designated decision maker, to include the criteria to when this would not apply for 1 of 1 agency. Findings include: The agency policy titled		welfare of the homehealth agency's employees would be at immediate and significant risk if thehome health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursablebased on applicable reimbursement requirements and the home health agency informs the patient of community resources toassist the patient following discharge; or (4) The patient no longer meets applicable regulatorycriteria, such as lack of physician’s order, and the home health agency informsthe patient of community resources to assist the patient following discharge. On 02/27/2025, The Administrator in-serviced allemployees on Agency’s revised discharge policy.	

	"Discharge Criteria and Planning" indicated patients are informed of discharge in a timely manner and acknowledges understanding reason. The agency discharge policy failed to evidence the requirement of 15 calendars days of notice prior to discharge. During an interview on 1/31/2025 at 4:19 PM, the Administrator relayed the discharge policy did not contain the requirement of 15 calendar days of notice, when it applied, prior to the discharge of patients.		The Clinical Supervisor has reviewed all activeclinical records and will ensure that all upcoming discharges comply withrevised discharge policy. Ongoing, 20% of clinical records will be auditedquarterly for evidence of a 15-day notice of discharge to patients, patient'slegal representative, or other individual responsible for the patient's care. Thedata will be included and analyzed as a part of QAPI activities and quarterlyreports. The Clinical Supervisor will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur. This deficiency will be corrected by 03/05/2025.	
N0506	Patient Rights 410 IAC 17-12-3(b)(2)(D)(iii)	N0506	TheAdministrator reviewed Patient Rights and conducted an in-service meeting on 02/27/2025 with all Agency staff	2025-03-05

	Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice. Based on record review and interview, the agency failed to ensure patients' rights were exercised when the agency failed to evidence they informed patients of the care that was to be furnished and be advised of a reasonable discharge notice in 9 of 9 closed clinical records reviewed (Patients #1, 2, 3, 4, 5, 6, 7, 8, 9). Findings include: 1. The agency policy titled "Consent for Treatment and Services" indicated the consent for treatment and services will be completed upon admission to agency to inform patients in advance regarding the care to be furnished. 2. The agency policy titled "Discharge Criteria and Planning" indicated patients are informed of discharge in a		toeducate on patient rights, including the right to be informed about the care tobe furnished, and of any changes in the care to be furnished and to be advisedof any change in the plan of care, including reasonable discharge notice. Also,the Agency must inform and distribute written information to the patientregarding Patient Rights at the time of the first home visit or before care isprovided. Starting 3/3/25, the Administrator will audit 100% ofnewly active patient records for 12 weeks for evidence of patients beinginformed of the care to be furnished. Starting 3/3/25, the Administrator will audit 100% ofdischarge records for 12 weeks for evidence of patients being provided a reasonabledischarge notice. Ongoing, the Administrator will audit 20% of patientcharts quarterly on these	

	timely manner and acknowledges understanding reason. The evaluation of discharge needs must be included in the medical record and discussed with patients or patient's representatives. 3. The clinical record for Patient #1 included an initial comprehensive assessment and a verbal order indicating services to be provided to Patient included SN visits once a week for nine weeks and HHA services twice a week for eight weeks, dated 5/2/2024. The clinical record failed to evidence Patient nor Patient's health care representative were informed of services to be provided by agency. The clinical record included a POC dated 8/30/2024 to 10/28/2024 and a verbal order dated 10/1/2024 for Patient discharge "due to no coverage," signed by the Alternate CM on 10/1/2024. The clinical record failed to evidence a notice of discharge was provided to Patient nor Patient's health care representative prior to discharge. During an interview on		requirements. The Administrator will be responsible for monitoringthese corrective actions to ensure that this deficiency is corrected and willnot recur. This deficiency will be corrected by 03/05/2025.	

	2/3/2025 beginning at 8:52 AM, Patient #1 revealed they were notified of discharge the same day of discharge. Patient relayed they required wound care as part of the home care treatment at the time of discharge. During an interview on 2/3/2024 beginning at 10:00 AM, the Alternate CM relayed there was no documentation of a discharge notice provided to Patient. During the same interview, the Administrator relayed the Patient was notified of services to be provided verbally and there was not documentation that Patient was informed.			

	4. The clinical record for Patient #2 included an initial comprehensive assessment, consents for care signed by Patient's representative, and a verbal order for SN services once a week for 9 weeks, PT and OT to evaluate and treat, and HHA services three times a week for eight weeks, dated 4/16/2024. The clinical record failed to evidence Patient or Patient's representative were notified of services the agency was providing. A POC dated 8/14/2024 to 10/12/2024 indicated services for the certification period to be SN visits once a week for one week then twice a week for eight weeks for assessments, education, medication review, and wound care. The clinical record included a verbal order dated 10/4/2024 for Patient discharge "due to no coverage," signed by the Alternate CM. The clinical record failed to evidence a discharge notice was provided to Patient nor Patient's health care representative prior to discharge. During an interview on 2/3/2025 at 8:30 AM, Other 1, family member and primary			

	caregiver for Patient, relayed the did not provide discharge notice. Other 1 revealed the agency care staff stopped providing home visits and when the agency was contacted, there was no answer. Other 1 relayed Patient was in need of wound care at the time the services stopped. During an interview on 2/4/2024 beginning at 10:00 AM, the Administrator relayed the agency staff RN was supposed to notify Patient of discharge and there was no documentation of discharge notification. The Administrator revealed the clinical record did not include notification of services to be provided to Patient at the start of care. 5. The clinical record for Patient #3 included an initial comprehensive assessment, consents for treatment signed by Patient, and a verbal order for SN services two times a week for 9 weeks, all dated 1/2/2024. The clinical record failed to evidence Patient was informed of services to be provided by agency. The clinical record included POC			

	dated 8/29/2024 to 10/27/2024 and an order for Patient discharge from agency "due to no coverage", signed by Alternate CM on 9/30/2024. The clinical record failed to evidence a discharge notice was provided to Patient prior to discharge. During an interview on 2/3/2025 at 1:33 PM, Other 2, family member and caregiver for Patient #3, revealed they were not notified by the agency that Patient was being discharged nor discharged. Other 2 relayed they found out the agency discharged Patient from a new home health agency that called to set up new care. Other revealed Patient required wound care at the time of discharge. During an interview on 2/4/2025 beginning at 10:00 AM, the Alternate CM relayed there was no documentation of Patient being notified of discharge. During the same interview, the Administrator revealed there was no documentation that Patient was informed of services to be provided by the agency. 6. The clinical record for Patient			

	#4 included an initial comprehensive assessment, consents for care, and a verbal order for SN services once a week for 9 weeks and PT to evaluate and treat Patient, all documented on 9/5/2024. The clinical record failed to evidence Patient was informed of services to be provided. The clinical record included a POC dated 9/5/2024 to 11/3/2024 and an order dated 9/25/2024 for agency discharge "due to no coverage" signed by the Alternate CM on 10/2/2024. The clinical record failed to evidence a discharge notice was provided to Patient prior to discharge. During an interview on 2/4/2025 beginning at 10:00 AM, the Alternate CM revealed there was no documentation that Patient was notified of discharge prior to discharge date. During the same interview, the Administrator relayed there was no documentation that Patient was informed of services to be provided by agency. 7. The clinical record for Patient #5 included an initial			

	consents for treatment signed by Patient's representative, and a verbal order for SN services once a week for 9 weeks, all documented on 8/23/2024. The clinical record failed include documentation that Patient nor Patient's representatives were notified of services to be provided by agency. The clinical record included an order to hold services due to Patient hospitalization, dated 9/12/2024 and signed by Alternate CM, and a transfer summary dated 9/20/2024. The clinical record included a verbal order dated 9/17/2024 to discharge Patient from agency due to hospitalization. The clinical record failed to evidence notification of pending discharge to Patient or Patient's representative prior to discharge. During an interview on 2/4/2025 beginning at 10:00 AM, the Alternate CM revealed there was no documentation of discharge notification prior to discharge. During the same interview, the Administrator relayed there was no documentation that Patient was notified of services to be			

	provided by the agency. 8. The clinical record for Patient #6 included an initial comprehensive assessment, consents for care signed by Patient, and a verbal order for SN services once a week for 9 weeks, all documented on 4/9/2024. The clinical record failed to evidence documentation that Patient was notified of services agency was to provide to Patient. The clinical record included a POC dated 8/7/2024 to 10/5/2024 and verbal order dated 9/30/2024 for Patient discharge. The clinical record failed to evidence a discharge notice was provided to Patient prior to discharge. During an interview on 2/4/2025 beginning at 10:00 AM, the Alternate CM revealed there was no documentation that Patient nor Patient representative were notified of discharge prior to being discharged. During the same interview, the Administrator relayed the services to be provided were not included on the consent nor was there documentation of notification			

	of services agency would be providing to Patient. 9. The clinical record for Patient #7 included an initial comprehensive assessment, consents for treatment signed by Patient, and a verbal order for SN services once a week for once week then twice a week for 8 weeks, all documented on 5/11/2024. The clinical record failed to evidence Patient was informed of services that were to be provided by the agency. The clinical record included a POC dated 9/8/2024 to 11/6/2024 and a verbal order dated 9/30/2024 for Patient discharge from agency "due to no coverage, signed by Alternate CM on 9/30/2024. The clinical record failed to evidence a discharge notice was provided to Patient prior to discharge. During an interview on 2/3/2025 at 9:50 AM, Patient relayed they were informed of being discharged on the same day as the last visit provided by the agency on 9/18/2024. Patient revealed wound care was part of the necessary treatment at the time of discharge.			

	During an interview on 2/4/2025 beginning at 10:00 AM, the Administrator relayed the services to be provided at start of care were verbally told to Patient but there was no documentation that Patient was notified. During the same interview, Alternate CM revealed there was not documentation of Patient being notified of discharge prior to discharge. 10. The clinical record for Patient #8 included an initial comprehensive assessment completed on 8/3/2024 and a physician order dated 8/3/2025 for SN visits once a week for one week, twice a week for eight weeks, then once a week for one week for assessments, education, medication review, and wound care. The clinical record included a consent for treatments signed by Patient's health care representative on 8/3/2025 that failed to indicate services that were to be provided. The clinical record failed to evidence documentation that Patient nor health care representative were informed of services to be provided.			

	The clinical record included POC dated 8/3/2024 to 10/1/2024 and a verbal order dated 9/30/2024 for Patient discharge "due to no coverage", signed by the Alternate CM on 9/30/2024, and the record included a discharge summary dated 9/30/2024. The clinical record failed to evidence a discharge notice was provided to Patient prior to discharge. During an interview on 2/4/2025 beginning at 10:00 AM, the Administrator relayed the clinical record did not include documented notification of services to be provided to Patient at the start of care. The Alternate CM revealed there was no documented notification of discharge provided to Patient, Patient's physician, nor Patient's health care representative. 11. The clinical record for Patient #9 included a Plan of care dated 9/11/2024 to 11/9/2024 that indicated services ordered as SN visits once a week for 9 weeks for assessments, medication review and education, and HHA services once a week for one week then twice a week for			

	eight weeks for personal care and ADL's. The clinical record included a verbal physician's order dated 9/26/2024 to discharge Patient from agency "due to no coverage", signed by the Alternate CM, and a discharge summary signed by Alternate CM on 10/9/2024. The last home visit SN visit completed was on 9/23/2024 and the last HHA visit was completed on 9/25/2024. The clinical record failed to evidence a discharge notice was provided to Patient prior to discharge. During an interview on 2/4/2025 beginning at 1:15 PM, the Administrator relayed the Patient was not provided a discharge notification.			
N0586	Scope of Services 410 IAC 17-14-1(h) Rule 14 Sec. 1(h) Home health aides must receive continuing education. Such continuing education shall total at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any eight (8) of the following subject areas: (1) Communications skills, including the ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff.	N0586	On02/27/2025, the Administrator in-serviced all home health aides on therequirement of continuing education. Such continuing education shall total atleast twelve (12) hours from January 1 through December 31, inclusive, with aminimum of eight (8) hours in any eight (8) of the following subject areas: (1)Communications skills,	2025-03-05

	(2) Observing, reporting, and documenting patient status and the care or service furnished. (3) Reading and recording temperature, pulse, and respiration. (4) Basic infection control procedures and universal precautions. (5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. (6) Maintaining a clean, safe, and healthy environment. (7) Recognizing emergencies and knowledge of emergency procedures. (8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and positioning. (12) Adequate nutrition and fluid intake. (13) Medication assistance. (14) Any other task that the home health agency may choose to have the home health aide perform.		including the ability to read, write, and make brief andaccurate oral presentations to patients, caregivers, and other home healthagency staff. (2)Observing, reporting, and documenting patient status and the care or servicefurnished. (3) Reading and recording temperature, pulse, and respiration. (4) Basic infection control procedures and universal precautions. (5) Basicelements of body functioning and changes in body function that must be reportedto an aide's supervisor. (6) Maintaining a clean, safe, and healthyenvironment. (7)Recognizing emergencies and knowledge of emergency procedures. (8) Thephysical, emotional, and developmental needs of and ways to work with the populationsserved by the home health agency, including the need for respect for thepatient, the patient's privacy, and the patient's property.	

	Based on record review and interviews the agency failed to ensure HHA received continuing education with a total of at least 12 hours annually in 2 of 2 HHA personnel files reviewed (HHA 1, HHA 2). Findings include: The agency document titled "Direct Care & Office Personnel In-Service Training Logs," dated 2023 indicated training completed and staff sign ins for 3/3/2023 and 6/9/2023. The agency failed to evidence they provided in-service training or education to HHA 1 and HHA 2 from 1/1/2024 to 12/31/2024. The personnel file for HHA 1, date of hire 11/5/2019, failed to evidence annual in-service training for 2024. The personnel file for HHA 2 , date of hire 9/13/2019, failed to evidence annual in-service training for 2024. During an interview on 2/3/2025 beginning at 11:45 AM, the Administrator relayed the last education provided to HHA 1 and HHA 2 were in 2023.		(9)Appropriate and safe techniques in personal hygiene and grooming that includethe following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and positioning. (12) Adequate nutrition and fluid intake. (13) Medication assistance. (14) Anyother task that the home health agency may choose to have the home health aideperform. Anin-service on 03/05/2025 was scheduled and will include the 2 required subjectareas: Basic infection control procedures &	

			Safetransfer techniques and ambulation. The rest of required subject areas trainingwill be scheduled throughout the year until December 31, 2025. 100% ofactive home health aide records will be audited annually in December by theAdministrator to ensure each home health aide receives continuing educationwith a total of 12 hours. TheAdministrator will be responsible for monitoring these corrective actions toensure that this deficiency is corrected and will not recur. This deficiency will be corrected by 03/05/2025.	
N0608	Clinical Records 410 IAC 17-15-1(a)(1-6) Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional	N0608	On 02/27/25,the Clinical Manager reviewed the Agency's policies and procedures: "Transfer/ReferralCriteria and Planning", "Discharge Summary", and the newly revised "DischargeCriteria and	2025-03-05

	standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interviews, the agency failed to ensure clinical records were maintained and included copies of summary reports sent to the person responsible for the medical component of the patient's care in 9 of 9 closed clinical records reviewed (Patients #1, 2, 3, 4, 5, 6, 7, 8, 9). Findings include: 1.The agency policy titled "Discharge Summary" indicated a discharge summary will be sent to the patient's primary care practitioner or other health care professional who is responsible for providing care to the patient within 5 business		Planning." The Clinical Manager inserviced all Agency staff on therequirement: All clinical records must contain pertinent past and currentfindings in accordance with accepted professional standards and must bemaintained for every patient, including copies of summary reports sent to theperson responsible for the medical component of the patient's care and adischarge summary. The inservice included specific training on ensuring properclinical records maintenance and ensuring that copies of summary reports aresent to persons responsible for the medical component of the patient's care. A dischargesummary will be sent to the patient's primary care practitioner or other healthcare professional who is responsible for providing care to the patient within 5business days. Starting 3/3/25, for 8 weeks, the	

	days. 2. The agency policy titled "Discharge Criteria and Planning" indicated physicians and care providers will be informed and knowledgeable of discharge and all necessary medical information pertaining to the patient's current course of illness and treatment and post-discharge goals will be sent to the receiving facility or health care provider to ensure a safe transition of care. 3. The clinical record for Patient #1 included a verbal order dated 10/1/2024 for Patient discharge "due to no coverage", signed by the Alternate CM on 10/1/2024, and a discharge summary dated 10/1/2024. The clinical record failed to evidence the discharge summary was provided to the person responsible for Patient's medical care. 4. The clinical record for Patient #2 included a verbal order dated 10/4/2024 for Patient discharge "due to no coverage", signed by the Alternate CM on 10/4/2024, and a discharge summary dated 10/4/2024,		charts weekly to ensure that clinical records contain pertinentfindings in accordance with accepted professional standards. Ongoing, 20% of active clinical records will beaudited quarterly to ensure that clinical records contain pertinent findings inaccordance with accepted professional standards. The data will be included in thequarterly Clinical Record Review report as a part of QAPI activities. The Clinical Supervisor will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur. This deficiency will be corrected by 03/05/2025.	

	11/19/2024. The clinical record failed to evidence a discharge summary report was provided to the person responsible for Patient's medical care. 5. The clinical record for Patient #3 included a verbal order dated 9/30/2024, signed by Alternate CM, for Patient discharge from agency "due to no coverage", and a discharge summary dated 9/30/2024. The clinical record failed to evidence a discharge summary report was provided to the person responsible for Patient's medical care. 6. The clinical record for Patient #4 included a verbal order dated 9/25/2024 for Patient discharge from agency "due to no coverage", documented by Alternate CM. The record included a discharge summary signed by Alternate CM on 10/2/2024. The clinical record failed to evidence a discharge summary report was provided to the person responsible for Patient's care. 7. The clinical record for Patient #5 included an initial POC dated 8/23/2024 to 10/21/2024 for SN			

	weeks. The clinical record included an order to hold services due to Patient hospitalization, dated 9/12/2024, a discharge summary dated 9/17/2024, and a transfer summary dated 9/20/2024 all signed by Alternate CM. The clinical record failed to evidence transfer summary nor discharge summary were sent to the person responsible for provided Patient's medical care. 8. The clinical record for Patient #6 included a verbal order dated 9/30/2024 for Patient discharge from agency, signed by the physician on 10/16/2024, and a discharge summary dated 9/30/2024, documented by RN 3. The clinical record failed to evidence the discharge summary was provided to the person responsible for Patient's medical care. 9. The clinical record for Patient #7 included a verbal order dated 9/30/2024 for Patient discharge from agency "due to no coverage", and the record included a discharge summary dated 9/30/2024, signed by RN 2 on 10/8/2024. The clinical record failed to evidence a			

	discharge summary report was provided to the person responsible for Patient's medical care. 10. The clinical record for Patient #8 included a verbal order dated 9/30/2024 for Patient discharge from agency "due to no coverage", and the record included a discharge summary dated 9/30/2024, signed by RN 2 on 10/8/2024. The clinical record failed to evidence a discharge summary report was provided to the person responsible for Patient's medical care. 11. The clinical record for Patient #9 included a Plan of care dated 9/11/2024 to 11/9/2024 that indicated services ordered as SN visits once a week for 9 weeks for assessments, medication review and education, and HHA services once a week for one week then twice a week for eight weeks for personal care and ADL's. The clinical record included a verbal physician's order dated 9/26/2024 to discharge Patient from agency "due to no coverage", signed by the Alternate CM, and a			

	Alternate CM on 10/9/2024. The clinical record failed to evidence a discharge summary report was provided to the person responsible for Patient's medical care. 12. During an interview on 2/4/2025 beginning at 10:00 AM, the alternate CM relayed the discharge summary for Patient #1, 2 and 8 was not sent to the physician. 13. During an interview on 2/4/2025 beginning at 1:15 PM, the Administrator relayed the discharge summary for Patient #3, 4, 5, 6, 7, and 9 was not sent to the physician.			
N0614	Clinical Records 410 IAC 17-15-1(c) Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to	N0614	TheAdministrator reviewed P & Ps: "Information Management Plan" and ensuredthat patient records are kept in a locked location with restricted access and thatoriginal clinical notes are stored in lockable filing cabinet. The office staffrearranged and organized both active and discharge records in order tosafeguard against loss or unauthorized use.	2025-03-05

	service. Based on record review and interviews, the agency failed to ensure clinical records were safeguarded against loss or unauthorized use. Findings include: 1. The agency policy titled "Privacy Practices", included in the patient admission folder, indicated the agency is required by law to maintain the privacy of patient health information. 2. On 1/31/2025 at 12:35 PM, surveyor entered via an unlocked door to the agency building. The agency, located on the 2nd floor, was entered via an open door. Upon entering the office, a desk at the entry of the agency was unoccupied, behind the desk was an open storage room with multiple boxes that contained medical records. One person was present in the agency office, the Alternate CM, who resided at a desk behind a partition. On top of another desk, in the office, were boxes containing approximately 40 medical		On02/27/25, the Administrator inserviced all employees on the requirement thatClinical record information shall be safeguarded against loss or unauthorizeduse. Written procedures shall govern use and removal of records and conditionsfor release of information. Patient's written consent shall be required forrelease of information not authorized by law. Current service files shall bemaintained at the main office from which the services are provided until thepatient is discharged from service. Closed files may be stored away from theparent or branch office provided they can be returned to the office withinseventy-two (72) hours. Closed files do not become current service files if thepatient is readmitted to service. The alternateClinical Manager will monitor maintenance of the privacy of patient healthinformation daily. This deficiency will be corrected by 03/05/2025.	

	records with patient names and discharge dates. Filing cabinets in the office were noted to be unlocked and were found to contain personnel files and medical personnel records. Storage closets with locks in the office were found containing the keys inside of the locks; these files contained files with patient medical information. During then entrance conference on 1/31/2025 beginning at 1:32 PM, the Administrator relayed the records were not secure, the person in charge of records was not present.			
N9999	Final Observations Authority IC 16-27-1.5-5 "Approved dementia training for home health aides" Sec. 5 (a) This section applies to a registered home health aide who: (1) is employed as a home health aide; and (2) provides care to an individual who has been diagnosed with or experiences symptoms of Alzheimer's disease, dementia, or a related cognitive disorder. (b) As used in this section, "approved dementia training" refers to a dementia training program: (1) for use in training home health aides in the care of individuals described in subsection (a)(2); and (2) that has been approved by the state	N9999	On02/27/25, the Administrator inserviced all current home health aides on therequirement "Approved dementia training for home health aides"pursuant to Section 16-27-1.5-5 effective 07/01/2022. Education included (a) Thissection applies to a registered home health aide who: (1) isemployed as a home health aide; and (2)provides care to an individual who has been diagnosed with	2025-03-05

	department under subsection (f). (c) Not later than sixty (60) days after the date on which a home health aide is initially hired to care for an individual with Alzheimer's disease, dementia, or a related cognitive disorder, the home health aide shall complete at least six (6) hours of approved dementia training. (d) Before December 31 of each year, a home health aide who has been employed as a home health aide for at least one (1) year shall complete at least three (3) hours of approved dementia training. (e) A home health aide who: (1) has received the training required by subsections (c) and (d); (2) has been employed as a home health aide for at least twenty-four (24) consecutive months; and (3) is hired by a home health agency; is not required to repeat the training required by this section. (f) The state department shall do the following: (1) Identify and approve each dementia training program that meets the following requirements: (A) The dementia training program includes education concerning the following: (i) The nature of Alzheimer's disease, dementia, and other related cognitive disorders. (ii) Current best practices for caring for and treating individuals with dementia. (iii) Guidelines for the assessment and care of an individual with dementia. (iv) Procedures for providing patient centered quality care. (v) The daily activities of individuals with dementia. (vi) Dementia related behaviors, communication, and positive intervention. (vii) The role of an individual's family in caring for an individual with dementia.		or experiences symptomsof Alzheimer's disease, dementia, or a related cognitive disorder. (b) Asused in this section, “approved dementia training” refers to a dementiatraining program: (1) foruse in training home health aides in the care of individuals described in subsection(a)(2); and (2) thathas been approved by the state department under subsection (f). (c) Notlater than sixty (60) days after the date on which a home health aide isinitially hired tocare for an individual with Alzheimer’s disease, dementia, or a relatedcognitive disorder, the home health aide shall complete at least six (6) hoursof approved dementia training. BeforeDecember 31 of each year, a home health aide who has been employed as a homehealth aide for at least one (1) year shall complete at least three (3) hoursof approved	

	(B) The dementia training program: (i) must be culturally competent; and (ii) may be provided online. (2) Establish and implement a process for state department approval of a dementia training program. (g) To the extent allowed by 42 CFR 484.80, the hours of approved dementia training completed under this section satisfies an equivalent number of hours of the home health aide training required by 42 CFR 484.80. (h) An entity that provides approved dementia training shall provide to each home health aide who successfully completes the training a certificate of completion. (i) A home health aide: (1) is responsible for maintaining the home health aide's certificate of completion; and (2) may use the certificate of completion as proof of compliance with this section. As added by P.L.44-2022, SEC.1. Authority IC 16-27-1.5-6 "Conditions required to administer gastrointestinal and jejunostomy tube feedings; training" Sec. 6 (a) A registered home health aide may administer gastrointestinal and jejunostomy tube feedings to a specific patient only if the following conditions are met: (1) The registered home health aide has completed the training curriculum described in subsection (b). (2) A registered nurse, providing registered nursing under IC 25-23-1-1.1(b)(6), either: (A) supervises the registered home health aide in administering the gastrointestinal and jejunostomy tube feedings; or (B) delegates responsibility for administering the gastrointestinal and jejunostomy tube		dementia training. (e) A homehealth aide who: (1) hasreceived the training required by subsections (c) and (d); (2) hasbeen employed as a home health aide for at least twenty-four (24) consecutive months;and (3) ishired by a home health agency; is not required to repeat the training requiredby this section. (f) Thestate department shall do the following: (1)Identify and approve each dementia training program that meets the following requirements: (A) Thedementia training program includes education concerning the following: (i) Thenature of Alzheimer’s disease, dementia, and other related cognitive disorders.	

based on the registered nurse's assessment of the registered home health aide's competency to administer gastrointestinal and jejunostomy tube feedings.

(3) The home health agency that the registered home health aide is employed with:

(A) allows the registered home health aide to administer gastrointestinal and jejunostomy tube feedings;

(B) establishes a procedure for:

(i) the delegation of the administration of gastrointestinal and jejunostomy tube feedings from a registered nurse to a registered home health aide that includes patient specific clinical parameters based on the registered nurse's assessment of the patient and the registered home health aide's competency to administer the gastrointestinal and jejunostomy tube feedings; and

(ii) the assessment by the registered nurse of the patient specific clinical parameters;

(C) retains documentation that the registered home health aide has completed the training curriculum described in subsection (b); and

(D) notifies each patient requiring gastrointestinal and jejunostomy tube feedings upon admission that the home health aide agency may allow registered home health aides to administer gastrointestinal and jejunostomy tube feedings.

(b) Training curriculum for home health aides to administer gastrointestinal and jejunostomy tube feedings must:

(1) be approved by the state department; and

(2) include the following concerning the administration of gastrointestinal and jejunostomy tube feedings:

(A) At least four (4) hours and not more than eight (8) hours of classroom training.

(B) At least two (2) hours and not more than four (4) hours of practical training.

(C) A written and practical examination administered by the trainer.

(c) A registered home health aide may not

(ii)Current best practices for caring for and treating individuals with dementia.

(iii)Guidelines for the assessment and care of an individual with dementia.

(iv)Procedures for providing patient centered quality care.

(v) Thedaily activities of individuals with dementia.

(vi)Dementia related behaviors, communication, and positive intervention.

(vii) Therole of an individual’s family in caring for an individual with dementia.

(B) Thedementia training program:

(i) mustbe culturally competent; and

(ii) maybe provided online.

(2)Establish and implement a process for state department approval of a dementia trainingprogram.

(g) To theextent allowed by 42 CFR 484.80, the hours of approved dementia training completedunder this section

	administer gastrointestinal and jejunostomy tube feedings until the home health aide has successfully: (1) completed the curriculum described in subsection (b); and (2) passed the examinations described in subsection (b)(2)(C). (d) The state department may require a registered home health aide who administers gastrointestinal and jejunostomy tube feedings under this section to annually complete not more than one (1) hour of in service training specific to the administration of gastrointestinal and jejunostomy tube feedings. (e) Before January 1, 2024, the state department must approve at least one (1) training curriculum described in subsection (b). As added by P.L.117-2023, SEC.6. Based on record review and interview the agency failed to ensure approved dementia training was provided to HHA who provided care to an individual diagnosed with a cognitive disorder in 2 of 2 HHA personnel files reviewed (HHA 1, HHA 2). Findings include:		satisfies an equivalent number of hours of the home health aidetraining required by 42 CFR 484.80. (h) Anentity that provides approved dementia training shall provide each home healthaide who successfully completes the training a certificate of completion. (i) A homehealth aide: (1) isresponsible for maintaining the home health aide's certificate of completion;and (2) mayuse the certificate of completion as proof of compliance with this section. 410 IAC16-27-1.5-5 Anapproved dementia training was scheduled on 03/05/2025, and will include the (i)The nature of Alzheimer's disease, dementia, and other related cognitivedisorders. (ii) Current best practices for caring for and treating individualswith dementia. Within the next 60 days after 03/05/2025, the 2nd and3rd approved dementia training will include the rest of	

	The clinical record for Patient #9 included a POC dated 9/11/2024 to 11/9/2024 that indicated Patient was forgetful, disoriented, and diagnoses included dementia. The POC included services ordered were SN and HHA services weekly for ADL's. HHA visits were documented on September 11, 16, 18, 23, and 25, of 2024. The personnel record for HHA 1, date of hire 11/15/2019, failed to evidence dementia training. The personnel record for HHA 2, dated of hire 9/13/2019, failed to evidence dementia training. During an interview on 2/3/2025 beginning at 11:45 AM, the Administrator revealed dementia training was provided for HHA 1 nor HHA 2.		educationconcerning (iii) Guidelines for the assessment and care of an individual withdementia. (iv) Procedures for providing patient centered quality care. (v)The daily activities of individuals with dementia. (vi) Dementia relatedbehaviors, communication, and positive intervention. (vii) The role of anindividual's family in caring for anindividual with dementia. That way, at the end of 3 training sessions, eachhome health aide would complete at least 6 hours of approved dementia training. 100% ofnewly hired home health aides will be audited within the first 60 days afterhiring date for evidence of completing at least six (6) hours of approveddementia training. 50% of allhome health aide personnel records who have been employed as a home health aidefor at least one (1) year will be audited quarterly	

			for documentation of completingany approved dementia training. 100% of these personnel records will be auditedannually in December for documentation of completing at least 3 hours ofapproved dementia training. TheAdministrator will be responsible for monitoring these corrective actions toensure that this deficiency is corrected and will not recur. This deficiency will be corrected by 03/05/2025.	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nerissa Abadilla	Administrator	3/6/2025 1:29:03 PM