STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED HOME HEALTHCARE INC	**1947 HARDER CT STE B , SCHERERVILLE, Indiana, 46375**

(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 The Indiana Department of Health conducted an Emergency Preparedness survey, conducted in accordance with 42 CFR §484.102, for a Home Health Provider and Suppliers. Survey Dates: October 21, 22, 23, and 24, 2024 Census: 73 QR: A 1 10/24/2024	E0000		
E0004	Develop EP Plan, Review and Update Annually CFR(s): 484.102(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop 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: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.	E0004		

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

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E0004	Continued from page 1 * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure they reviewed and/or updated their emergency preparedness plan at least every 2 years in 1 of 1 agency. Findings include: The agency's emergency preparedness plan was presented for review on 10/24/24; the plan included the date of the last revision and update 11/22/2021. On 10/24/2024 at 2:30 PM, the alternate administrator indicated the last revision or review of the agency's emergency preparedness plan was on 2021.	E0004		
E0013	Development of EP Policies and Procedures CFR(s): 484.102(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement	E0013		

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E0013	Continued from page 2 emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to evidence their policies and procedures were reviewed and updated at least every 2 years. Findings include: The agency's emergency preparedness policy was presented for review on 10/24/24; the policy failed to evidence a review or update since 5/22/2019. On 10/24/2024 at 2:30 PM, the alternate administrator	E0013		

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E0013	Continued from page 3 indicated the last revision or review of the agency's emergency preparedness policy was in 2019.	E0013		
E0036	EP Training and Testing CFR(s): 484.102(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).	E0036		

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E0036	Continued from page 4 *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to evidence their emergency preparedness plan included a training and testing program / plan in 1 of 1 agency. Findings include: The agency's emergency preparedness plan, presented for review on 10/24/24, failed to evidence a training and testing program, based on the agency's plan. On 10/24/2024 beginning at 2:30 PM, the alternate administrator indicated he had no evidence of a training program nor training of their staff to the agency's emergency preparedness plan.	E0036		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: October 21, 22, 23, and 24, 2024 12-Month Unduplicated Skilled Admissions: 144 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. On 10/21/24 at 11:14 AM, Administrator was notified the survey was partially extended. Acronyms: RN - Registered Nurse, SN - Skilled Nurse, POC- Plan of Care, HHA- Home Health Aide, SOC- Start of Care, PT - Physical Therapist, SW- Social Worker QR: 11/04/2024, A1	G0000		
G0418	Patient's or legal representative's signature	G0418		

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G0418	Continued from page 5 CFR(s): 484.50(a)(2) Obtain the patient's or legal representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities. This ELEMENT is NOT MET as evidenced by: Based on record review and interviews, the agency failed to evidence the patients' legal representative's signature confirming that they received a copy of patient rights and responsibilities in 2 of 3 active clinical records reviewed with a home visit (Patients #2 and #3). Findings include: 1.The clinical record for Patient #2 included an initial comprehensive assessment completed on 10/15/24 by RN 1 that indicated Patient primary diagnosis was dementia. The comprehensive assessment included that Patient had decreased alertness, decreased cognition, confusion, required 24-hour supervision, and was alert to person and confused to place and time. The record included a consent for services, Patient's rights and responsibilities, a statement of financial responsibility, and authorization to release medical record information signed by Patient #2 on 10/15/24. The record failed to evidence the signature of Patient's health care representative. During an interview on 10/22/24 beginning at 4:00 PM, Administrator relayed the Patient had dementia and Patient's family member was the power of attorney, who should have been involved in signing for Patient's care. 2. The clinical record for Patient #3 included an initial comprehensive assessment completed on 10/10/24 by RN 2 which indicated Patient was alert to person and place, not alert to time, had a memory deficit, with cognitive impairment and needing 24 hour supervision, and resided in an assisted living facility. The record included a consent for services, Patient's rights and responsibilities, a statement of financial responsibility, and authorization to release medical record information signed by Patient #3 on 10/10/24. The record failed to evidence the identification nor a signature of Patient's health care representative. During an interview on 10/22/24 beginning at 3:00 PM, Administrator relayed Patient was confused at times, Patient's family member was the health care	G0418		

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G0418	Continued from page 6 representative, and there was not a signature from the family member. 410 IAP 17-12-3(a)(2)	G0418		
G0484	Document complaint and resolution CFR(s): 484.50(e)(1)(ii) (ii) Document both the existence of the complaint and the resolution of the complaint; and This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure complaints and resolutions were documented in 1 of 1 agency. Findings include: During the entrance conference with the administrator and clinical supervisor, on 10/21/24 beginning at 10:23 AM, the Administrator relayed both she and the Clinical Supervisor oversee complaints. The administrator relayed she investigates the complaints received. The complaint log was requested within one hour of the conclusion of the entrance conference; at 11:20 AM, the Clinical Supervisor revealed there was not a complaint log to be provided for review. During an interview on 10/24/24 beginning at 2:25 PM, Clinical Supervisor relayed the agency had received complaints and Administrator handled them without documentation. During an interview on 10/24/24 beginning at 4:15 PM, Administrator revealed she had received complaints, investigated, and resolved the complaints and relayed there was no documentation to provide. 410 IAP 17-12-3(c)(2)	G0484		
G0514	RN performs assessment CFR(s): 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner -	G0514		

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G0514	Continued from page 7 ordered start of care date. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure an initial assessment was conducted within 48 hours of referral in 3 of 5 active records reviewed (Patients #3, 6, and 7) Findings include: 1 .The agency policy titled “Admission Criteria and Process,” revised 5/2010, indicated the Clinical Supervisor will assign personnel to conduct the initial assessment within 48 hours of referral or discharge from the referring facility. During the entrance conference on 10/21/24 beginning at 10:23 AM, Administrator relayed the agency initial assessments are completed at the same time as the start of care comprehensive assessment. 2. The clinical record for Patient #3 included a referral for home health services dated 10/02/2024; the record revealed the initial assessment was the comprehensive assessment dated 10/10/2024. The record failed to evidence physician notification of the delayed initial assessment nor an order for the delay in assessment. During an interview on 10/22/2024 beginning at 3:00 PM, the Administrator relayed the agency did not see the Patient within 48 hours and there was not a physician’s order nor notification for the delay. 3. The clinical record for Patient #6 included a home health referral dated 8/6/24; the record revealed the initial assessment was the comprehensive assessment dated 8/09/2024. The record failed to evidence physician notification of the delay in the initial assessment nor an order for the delay. During an interview on 10/23/24 beginning at 3:30 PM, the Clinical Supervisor relayed the time between the referral and initial assessment was three days and there was not order for the delay. 4. The clinical record for Patient #7 included a referral for home health services, dated 10/01/2024; the record revealed the initial assessment was the comprehensive assessment dated 10/12/2024. The record failed to evidence a physician notification for the delay the initial assessment nor an order for the delay.	G0514		

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G0514	Continued from page 8 During an interview on 10/24/24 beginning at 12:30 PM, the Administrator relayed Patient was not answering the phone when they attempted to schedule the initial assessment. The administrator indicated she had not completed the assessment documentation. 410 IAP 17-14-1(a)(1)(A)	G0514		
G0536	A review of all current medications CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the comprehensive assessment that accurately reflects the patient's status including a review of all medications in 1 of 3 active clinical record reviewed with a home visit (Patient #6). Findings include: The clinical record for Patient #6 included the comprehensive assessment, dated 8/09/2024, which identified Patient's medications: Atorvastatin, Diclofenac, Levothyroxine, Linzess, Tresiba, Plavix, Lasix, Neurontin, Oxygen, Metolazone, Metoprolol, Lidocaine topical, Renvela, Omeprazole, Novolog, Acetaminophen, Bentyl, Tramadol, and Norco. The electronic medical record failed to evidence the medications were evaluated for potential or actual interactions and the severity, Atorvastatin, Diclofenac, Levothyroxine, Linzess, Tresiba, Plavix, Lasix, Neurontin, Metolazone, Lidocaine topical, Renvela, Omeprazole, nor Novolog. During an interview on 10/23/24 beginning at 3:30 PM, Clinical Supervisor relayed there were medications excluded from the interaction assessment and it needed to be reassessed. 410 IAP 17-14-1(a)(1)(B)	G0536		
G0538	Primary caregiver(s), if any	G0538		

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G0538	Continued from page 9 CFR(s): 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; This ELEMENT is NOT MET as evidenced by: Based on record review and interviews, the agency failed to ensure the comprehensive assessment accurately reflected the patient's primary caregivers and available supports including their willingness and ability to provide care in 2 of 5 active clinical records reviewed (Patients #2, 7). Findings include: 1 .The agency policy titled "Initial and Comprehensive Assessment," revised 5/2010, indicated the comprehensive assessment should include a review of patient and family /caregiver support systems and type of care the family/caregiver was available, capable, and willing to provide. 2. The clinical record for Patient #2 included an initial comprehensive assessment completed on 10/15/24 by RN 1 that indicated Patient primary diagnosis was dementia. The assessment included Patient had decreased alertness, decreased cognition, confusion, required 24-hour supervision, was alert to person, and confused to place and time. The assessment included Patient lived with a family member. The record failed to evidence the ability and availability assessment of Patient's caregiver(s). During an interview on 10/22/24 beginning at 4:00 PM, Clinical Supervisor relayed the abilities and availability of the caregiver was not included / nor assessed in the comprehensive assessment. 3. The clinical record for Patient #7 included an initial comprehensive assessment dated 10/12/24 and signed by RN 2 that indicated Patient had a diagnosis of multiple sclerosis (a chronic nervous system disease with the brain and spinal cord) with bed confinement, required 24 hours supervision, had intermittent confusion, a memory deficit, and was dependent on assistance for activities of daily living (bathing, dressing, grooming, eating, and mobility). The assessment included Patient lived with family member who was available to Patient when not at work; the	G0538		

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G0538	Continued from page 10 assessment failed to evidence with willingness nor schedule of Patient's caregiver nor additional support required when Patient's family member was not present. During an interview on 10/24/2024 beginning at 12:30 PM, the Clinical Supervisor relayed he would have to contact RN 2, the admitting RN to ask what support systems are in place for Patient's care as was not in the assessment.	G0538		
G0546	Last 5 days of every 60 days unless: CFR(s): 484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. This ELEMENT is NOT MET as evidenced by: Based on record review and interviews the agency failed to update the comprehensive assessment with a significant change in condition in 1 of 2 active clinical records reviewed with a wound (Patient #4). Findings include: 1 .The agency policy titled "Reassessments /Recertification," revised 5/2010, indicated the comprehensive reassessment must be performed as often as warranted by the condition of the patient. 2. The clinical record for Patient #4 included a recertification comprehensive assessment dated 8/23/24, conducted by RN 2; the assessment included a wound vacuum (suction device for wound healing) to Patient's sacrum (tailbone area) was in use. A physician's order dated 9/18/24 revealed the wound vacuum was discontinued, a new wound care order was received. Incident documentation and Infection documentation, dated 9/25/24, indicated Patient's wound size increased in width from 2.4 cm. in the comprehensive assessment to 3.0 cm on 9/25/24 and with the presence of an infection. Documentation evidenced the wound width was measured to be 3.5 cm. on 10/09/2024, with no change in the length	G0546		

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G0546	Continued from page 11 and depth. The clinical record failed to evidence a comprehensive reassessment after 9/18/24 to reflect Patient's current health status. During an interview on 10/23/24 beginning at 3:00 PM, Clinical Supervisor relayed the comprehensive assessment should have been revised with Patients' wound condition changes and was not updated. 410 IAP 17-14-1(a)(1)(B)	G0546		
G0564	Discharge or Transfer Summary Content CFR(s): 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. This STANDARD is NOT MET as evidenced by: Based on interview and record review, the agency failed to ensure a transfer summary and other pertinent information was sent to the receiving health care facility in 1 of 2 discharged records reviewed with a transfer for emergent services [Patient #1]. The clinical record for Patient #1, included a communication note dated 10/10/24, which relayed Patient sought emergent services on 10/09/24 and was hospitalized. Patient #1's recertification period ended on 10/15/24. The clinical record failed to evidence a transfer summary was sent to the health care provider within 48 hours of knowledge of the hospitalization. The clinical record failed to evidence a discharge summary was written and sent to attending provider, as of 10/24/24. During an interview, on 10/24/24, beginning at 10:55 AM, Administrative Staff 2 indicated the transfer summary was not sent to the provider until 10/21/24 and indicated they have not discharged Patient, therefore no discharge summary was written.	G0564		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi)	G0574		

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G0574	Continued from page 12 The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the plan of care included all treatments, services, and medications in 5 of 5 active clinical records reviewed (Patients #2, 3, 4, 6, and 7).	G0574		

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G0574	Continued from page 13 Findings include: 1.The clinical record for Patient #2 included a POC dated 10/15/24 to 12/13/24, signed by RN 1, included Patient's psychosocial status, as "MSW [masters of social work] referral needed for access to community resources." The clinical record failed to evidence an order or referral for a SW nor physician's notification regarding a delay in SW services. During an interview on 10/24/2024 beginning at 10:35 PM, the Clinical Supervisor relayed the RN 1 forgot to notify him regarding the referral on 10/15/2024and revealed he input a SW consult order on 10/24/2024. 2. The clinical record for Patient #3 indicated the SN conducted the initial comprehensive assessment on 10/10/2024, identified Patient resided in an assisted living facility [ALF], Entity C, and established the start of care. The clinical record evidenced HHA visits were conducted on 10/10/2024 and 10/15/2024. The POC failed to evidence orders for the care provided by the SN on 10/10/2024 and the HHA services provided; the POC failed to evidence the services provided by the ALF. During an interview on 10/22/2024 beginning at 12:15 PM, the director of nursing at assisted living facility, Other D, relayed Patient was able to ambulate with assistance and the ALF provided call light services. During an interview on 10/22/24 beginning at 3:00 PM, the Administrator relayed the SN and HHA services were not included on the POC and the clinical Supervisor relayed the ALF was not included in the POC. 3. The clinical record for Patient #4 included a POC dated 8/25/2024 to 10/23/2024 with SN care visits three times eight weeks the once a week for one week for wound care. The clinical record included faxed documents from Entity G, a wound care clinic, dated 7/29/2024 with a faxed date received of 8/20/2024. A communication note dated 9/25/2024 documented by Administrator indicated Patient had a wound clinic appointment 9/23/2024 with changes in medication and wound care. The POC failed to include Entity G, a wound care clinic, providing care to Patient, and the treatments therein. 4. During a home visit observation on 10/23/24 beginning at 11:30, Patient #6 had a personal care assistant present from an outside home health agency, Entity E. Patient revealed they are on a fluid restriction of ½ glass of water for each day. During	G0574		

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G0574	Continued from page 14 the home visit, a meal support service arrived to deliver food. The clinical record review for Patient #6 included a POC dated 10/08/2024 to 12/06/2024 which included the diet order of a renal diet, low cholesterol, low fat, no concentrated sweets, and high fiber. Nursing instructions indicated to monitor hemodialysis (treatment to filter waste and excess fluid from blood) site, a right arteriovenous fistula (surgically connected artery and vein for dialysis). The POC failed to evidence Patients' fluid restriction, the meal delivery /support service Patient received, Entity E who provided Patients' personal care, nor the safety and care to Patient's right arteriovenous fistula. According to the National Kidney Foundation, a limb with an arteriovenous fistula should not be used for blood pressure measurement, blood draws, nor any pressure to the site. During an interview on 10/23/2024 beginning at 3:30 PM, Clinical Supervisor relayed he was unaware of other services Patient was receiving in the home. 5. The clinical record review for Patient #7 included a POC dated 10/12/2024 to 12/10/2024, signed by RN 2, failed to evidence the discipline and their frequency to be provided. The record included a physician's order, dated 10/12/2024, with SN services ordered one time per week for nine weeks. During an interview on 10/24/2024 beginning at 12:30 PM, Clinical Supervisor relayed the ordered disciplines nor frequencies were included in the POC. 410 IAC 17-13-1(a)(1)(B), 17-13-1(a)(1)(D)(ii, iii, xii, ix, x)	G0574		
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure that drugs, services, and treatments are administered only as ordered by a physician in 1 of 2 active clinical records reviewed without a home visit (Patient #7).	G0580		

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G0580	Continued from page 15 Findings include: 1 .The agency policy titled “Physician Participation in Plan of Care,” revised 5/2010, indicated the attending physician’s verbal certification will be obtained at the time the plan of care is established then sign the POC within 45 days of SOC. 2. The agency policy titled “Verification of Physician Orders,” dated 5/2010, indicated to ensure accurate physician orders, orders will be documented on the order form, dated, and signed. 3. The clinical record for Patient #7 included the initial SN visit was conducted on 10/12/2024; the visit note documentation indicated wound care was provided to the right foot, cleansed the wound with normal saline, apply xeroform, cover and secure. The clinical record included a physician’s order, dated 10/12/2024, that indicated SN visits were to be provided once per week for nine weeks for unspecified wound care. The clinical record failed to evidence a specified order for wound care that included cleansing with normal saline, to apply xeroform, cover, and secure. During an interview on 10/24/24 beginning at 12:30 PM, the Clinical Supervisor relayed there was not documentation in the clinical record of a physician’s order, verbal nor written, for the wound care provided on 10/12/2024 and throughout the certification period. the clinical supervisor indicated the order was on the unsigned POC. 410 IAP 17-13-1(a)	G0580		
G0606	Integrate all services CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure services were integrated, whether provided directly or under arrangement, to ensure identification of patient needs in three of 5 active clinical records	G0606		

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G0606	Continued from page 16 reviewed (Patients #3, 4, 6). Findings include: 1 .The agency policy titled “Coordination of Services with Other Providers,” revised 5/2010, indicated the case manager assigned to patient would be responsible for coordinating services provided to the patient, including acting as a liaison with other organizations providing care to the patient. 2. The clinical record for Patient #6 included a communication note dated 9/12/24 that indicated Patient went to Entity F on Tuesdays, Thursdays, and Saturdays for treatment. The POC dated 10/08/2024 to 12/06/2024 failed to include Entity F nor the treatment schedule. During a home visit observation on 10/23/24 beginning at 11:30, Patient #6 a personal care assistant was present from another home health agency, Entity E. During an interview on 10/23/24 beginning at 11:20 AM, RN 4 relayed she had not coordinated care with Patient’s Dialysis facility, Entity F, nor Entity E, another home health service providing care to Patient. During an interview on 10/23/24 beginning at 3:30 PM, Clinical Supervisor relayed he was not aware of what type of dialysis, what days, nor where Patient received dialysis. He was not aware Patient received personal care services from an outside agency. 3. The clinical record review for Patient #4 included a POC dated 8/25/2024 to 10/23/2024 with orders for wound care by the SN three times a week for eight weeks, then once a week for the last week of the certification period. The clinical record included faxed documents from Entity G, a wound care clinic, dated 7/29/2024, date received by fax was 8/20/2024. A communication note dated 9/25/2024, documented by the Administrator, indicated Patient had a wound clinic appointment on 9/23/2024 and changes in medication and their wound care orders. The clinical record failed to evidence updates, orders, and progress notes from Entity G since 8/20/2024. During an interview on 10/23/24 beginning at 3:00 PM, Administrator relayed RN 2 contacts the wound clinic for Patient #4 and could not provide evidence of service integration. 4. The clinical record for Patient #3 included an initial comprehensive assessment dated 10/10/2024, conducted by RN 2; the assessment indicated Patient was	G0606		

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G0606	Continued from page 17 alert to person and place, not alert to time, and had a memory deficit, cognitive impairment, needed 24 hour supervision, and resided in an assisted living facility. During a home visit observation on 10/22/2024 beginning at 12:30 PM, Patient resided in an assisted living facility, Entity C. During an interview on 10/22/24 beginning at 12:30, Administrator relayed the agency had not coordinated care with Entity C. 410 IAP 17-12-2(h)	G0606		
G0808	Onsite supervisory visit every 14 days CFR(s): 484.80(h)(1)(i) (1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech language pathology services— (A) A registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in paragraph (g) of this section, must complete a supervisory assessment of the aide services being provided no less frequently than every 14 days; and (B) The home health aide does not need to be present during the supervisory assessment described in paragraph (h)(1)(i)(A) of this section. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the supervisory assessment of a home health aide (HHA) was completed no less frequently than every 14 days in 1 of 1 active clinical record reviewed with a gastronomy tube (Patient #4). Findings include: 1 .The agency policy titled “Home Health Aide	G0808		

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G0808	Continued from page 18 Supervisory Visits," revised 5/2010, indicated supervisory visits must be conducted at least every 14 days and documented in the medical record. 2. The clinical record for Patient #4 included a POC dated 8/25/2024 to 10/23/2024 with orders for SN services to be provided three times a week for eight weeks, then once a week for one week and HHA services to be provided twice a week for eight weeks then once a week for one week. The record included documentation of a HHA supervisory visit was completed on 8/19/2024. HHA visits were documented for Patient #4 on August 29, September 03, 05, 09, 12, 16, 18, 23, 26, 30, October 03, 07, 10, 14, 17, and 21, 2024. The record failed to evidence a HHA supervisory visit completed after 8/19/24 through 10/23/2024. During an interview on 10/23/24 beginning at 3:00 PM, Clinical Supervisor relayed he did not see any HHA supervisory visits completed since August 19, 2024.	G0808		
G0810	If concern identified, direct observation CFR(s): 484.80(h)(1)(ii) The supervisory assessment must be completed onsite (that is, an in person visit), or on the rare occasion by using two-way audio-video telecommunications technology that allows for real-time interaction between the registered nurse (or other appropriate skilled professional) and the patient, not to exceed 1 virtual supervisory assessment per patient in a 60-day episode. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the agency failed to ensure the HHA supervisory assessment was completed onsite or on the rare occasion by using two way audio video telecommunications in 1 of 2 active patient records reviewed with a home visit and home health aide services (Patient #6). Findings include: 1 .The agency policy titled “Home Health Aide Supervisory Visits,” revised 5/2010, indicated supervisory visits must be conducted at least every 14 days at the patient’s residence. 2. The clinical record for Patient #6 included a POC dated 10/08/2024 to 12/06/2024 with SN visits once a week for nine weeks and HHA care visits twice a week for eight weeks. HHA home visits were documented on	G0810		

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G0810	Continued from page 19 10/14/24 and 10/21/24. HHA supervision visit documentation was dated 10/09/2024 and 10/23/2024 by RN 4. During a home visit observation on 10/23/2024 beginning at 11:30, RN 4 was observed to conduct an assessment on Patient #6; the visit observed did not include an assessment of the HHA care provided to Patient #6. During an interview on 10/24/2024 beginning at 12:15 PM, RN 4 revealed she asked Patient #6 about the HHA care during a telephone call, prior to the 10/23/2024 home visit. RN 4 relayed she will complete supervision assessments via phone call or text about 25% of the time.	G0810		
G0948	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the administrator failed to evidence they were responsible for the day to day operations of their agency. Findings include: 1.During the entrance conference on 10/21/24, the administrator relayed the provide SW services indirectly, by contract. The contract with the SW, dated 10/21/24, was reviewed; the contract failed to evidence the signature of the Administrator. During an interview on 10/21/24 beginning at 3:20 PM, the Administrator relayed she did not have the original contract, she requested a new contract, which is not yet signed. 2. On 10/21/24, the entrance conference was conducted from 10:25 AM to 11:00 AM; during the conference it was reviewed and requested a list of the agency's' active patients that received skilled services and requested a list of their clinicians' scheduled visits for 10/21/2024, 10/22/2024, and 10/23/2024. 3. During an interview on 10/21/2024 beginning at 12:00 PM, the Clinical Supervisor relayed Other A, their quality assurance employee, would provide the active patient list and the clinician's' visit schedules. The Clinical Supervisor relayed he did not keep track the	G0948		

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G0948	Continued from page 20 skilled clinicians visits; he relayed Other A was gathering the information and compiling the lists. 4. On 10/21/2024 at 12:30 Other A (quality assurance employee) relayed he tracked patient visits, made sure the visits are completed, and he kept track of the census. The Clinical Supervisor relayed he tracked visits when patients call in and ask when their next visit would be expected. The Clinical supervisor relayed the clinical staff schedule their own patient visits; he revealed the staff should call the agency if unable to complete a patients' visit. The clinical supervisor indicated to provide a list of patient visits scheduled for the dates requested, he would need to call each clinician to determine when they have scheduled a patients' visit, the date and time. 5. On 10/21/2024 at 3:15 PM, Other A provided the agency's visits scheduled for their SN's and HHA's for 10/21/2024. At 4:35 PM, Other A provided a list of the agency's active patients. 6. On 10/23/24 at 9:10 AM, a list of skilled nurse visits scheduled to be conducted on 10/23/24 was requested from the Clinical Supervisor. At 9:25, the Clinical Supervisor relayed agency staff were working on the visit list. A list of the SN visits scheduled for 10/23/2024 was not received from the agency. On 10/23/24 beginning at 10:00 AM, the clinical record for Patient #4 revealed a skilled nurse visit was scheduled and due on 10/23/2024, to conduct a comprehensive reassessment as the certification ended on 10/23/2024; the record failed to evidence the recertification comprehensive assessment was completed. A request was made to the clinical supervisor, to observe the home visit of RN 2 with Patient #4 on 10/23/2024. The Clinical Supervisor relayed RN 2 was scheduled for the visit, though could not conduct, as scheduled, and relayed he was unsure who would be able to conduct the visit as was due 10/23/2024. On 10/24/2024 at 9:30 AM, the Clinical Supervisor relayed that RN 2 completed the comprehensive assessment on 10/23/24. The clinical record of Patient #4 on 10/24/24, included a comprehensive reassessment visit was documented by RN 2 from 10:45 AM to 11:45 Am. 7. The agency policy titled “Storage of Medications and Nutritional Products,” revised 5/2010, indicated medications will be stored in appropriate storage temperatures utilizing thermometers and temperature	G0948		

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G0948	Continued from page 21 logs, protected from contamination. During an observation of agency operations on 10/21/24 beginning at 11:00 AM, an influenza vaccine product was identified stored, unopened, in a refrigerator with food and food products. The label on the influenza vaccine product indicated medication should be stored at 35-46 degrees Fahrenheit. In addition, 3 boxes of Tubersol (used for intradermal tuberculin testing) were noted on the reception desk, at room temperature. 2 of the 3 boxes were expired, one in 2021 and one in 2022. The 3rd box was with an expiration date of 5/2027, lot number 3CA19C1, and was opened. During an observation on 10/22/24 beginning at 3:10 PM, the vial of Tubersol with the 2027 expiration date was on the desk in the agency's reception area. The review of the Food and Drug Administration package insert for Tubersol indicated the product should be stored at 35 to 46 degrees Fahrenheit. During an interview on 10/21/24 beginning at 11:00, the Administrator relayed their refrigerator where they stored their biologicals, was broken. The Clinical Supervisor relayed the previous refrigerator, in which they kept the tubersol and other biologicals, did not have a thermometer, the temperature was not monitored, and they did not have a separate refrigerator in which to store the biologicals. During an interview, on 10/22/24 beginning at 3:10 PM, the Administrator revealed five employees received a Tubersol solution from the vial with expiration date 2027, after it was kept at room temperature. 410 IAC 17-12-1(c)(1)	G0948		
G0954	Ensures qualified pre-designated person CFR(s): 484.105(b)(2) When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to evidence a pre-designated person was authorized in	G0954		

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G0954	Continued from page 22 writing to fulfill the role of the alternate administrator, in the event the administrator was unable to fulfill the role, for 1 of 1 agency. Findings include: The governing body minutes were provided by the administrator for review; the most recent meeting minutes provided were dated 12/20/2023 and 11/24/2021. The minutes failed to evidence documentation designating the Alternate Administrator. During an interview on 10/21/24 beginning at 2:25 PM, the Administrator relayed she did not have Governing Body meeting minutes appointing the Alternate Administrator. 410 IAC 17-12-1(b)	G0954		
G1024	Authentication CFR(s): 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure clinical record entries were appropriately authenticated in 1 of 1 active clinical record reviewed with an indwelling urinary catheter (Patient #4). Findings include: The clinical record review for Patient #4 included a POC dated 8/25/2024 to 10/23/2024 with SN services for wound care, three times a week for eight weeks, then once a week for one week. A physician's order, dated 9/18/2024, included a change in frequency; the SN to provide wound care twice a week and included new wound care orders. The clinical record indicated 2 SN visits were scheduled for the week of 10/13/24 to 10/19/24, scheduled for 10/16/24 and 10/18/24; as of 10/22/2024, neither visit were documented as completed nor otherwise. The record failed to evidence physician	G1024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED HOME HEALTHCARE INC	1947 HARDER CT STE B , SCHERERVILLE, Indiana, 46375

(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
G1024	Continued from page 23 orders to change the frequency nor notification that the visits were not conducted. The POC indicated a SN was to insert a foley catheter (indwelling urinary catheter) every month and as needed. A SN visit note, dated 8/05/2024, noted Patients' Foley catheter was changed. The record failed to evidence documentation of a foley catheter change /insertions after 8/05/2024 through 10/22/24. On 10/23/2024, the clinical record revealed a SN visit note, dated 9/04/2024 which indicated a foley catheter change. The electronic medical record [EMR] activity log indicated the visit note was updated and completed by Other A, their quality assurance employee. During an interview on 10/22/24 beginning at 3:35 PM, RN 3 relayed they saw Patient once during the week, on 10/16/2024 and indicated the 10/16/2024 visit was not documented. RN 3 indicated they did not conduct a 2nd visit of the week, scheduled for 10/18/2024. RN 3 indicated 10/18/2024 was missed, was not conducted on another date, indicated this was not documented in the clinical record, nor was the attending notified nor was there an order received, to change in the frequency of the SN services to be provided. During an interview on 10/22/24 beginning at 3:40 PM, Clinical Supervisor relayed he was unaware of the missed visit on 10/18/24 and the RN should have coordinated with him. During an interview on 10/23/24 beginning at 3:00 PM, the Administrator relayed she assisted in documenting the 9/04/2024 SN foley change documentation for Patient #4; the Administrator revealed she did not do the task and did not know if the task was completed. During an interview on 10/24/24 beginning at 9:05 AM, Other A, agency's quality assurance staff, relayed he updated the 9/04/2024 tasks, changed to a Foley catheter task. Other A stated he did not have a nurse licensure nor did he complete Patients' Foley change. 410 IAC 17-15-1(b)	G1024		
G1028	Protection of records CFR(s): 484.110(d) Standard: Protection of records. The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with	G1028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED HOME HEALTHCARE INC	**1947 HARDER CT STE B , SCHERERVILLE, Indiana, 46375**

(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
G1028	Continued from page 24 the rules regarding protected health information set out at 45 CFR parts 160 and 164. This STANDARD is NOT MET as evidenced by: Based on observations and interviews the agency failed to ensure the clinical records were safeguarded against loss or unauthorized use in 1 of 1 agency. Findings include: 1 .The agency policy titled “Safeguarding/Retrieval of Clinical/Service Record,” revised 5/2010, indicated all patient clinical /service records will be maintained in locked, waterproof file cabinets in a record room. The record room will not be left unattended during working hours and only authorized personnel will have access. 2. During an observation of the agency on 10/23/24 at 12:30 PM, multiple boxes were observed in the Clinical Supervisor’s office; the boxes were labeled, some were labeled Palmetto and Medicare, others labeled 2016, 2021, or 2022. The contents of one box was noted to contain Patient medical records. The door to this office was next to the agency's back entrance door, that was unlocked and allowed for entry from the outside at time of observation. 3. During an interview on 10/23/24 beginning at 12:30, Clinical Supervisor relayed the back door and his office door was kept unlocked during business hours and revealed he often left his office unoccupied to work in another office in the building. 410 IAC 17-12-3(b)(3)	G1028		