STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K034	A. BUILDING B. WING	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPOINTE HEALTHCARE	5620 INDUSTRIAL ROAD, FORT WAYNE, IN, 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: 11/21/24, 11/22/24, 11/25/24, 11/26/24, 11/27/24, 12/02/24, 12/03/24, 12/04/2024 Active Census: 49 At this Emergency Preparedness survey, Homepointe Healthcare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home	G0000		

	Health Provider. Survey Dates: 11/21/24, 11/22/24, 11/25/24, 11/26/24, 11/27/24, 12/02/24, 12/03/24, 12/04/2024 The survey was announced as partially extended on 11/22/24 at 2:51 PM. 12-Month Unduplicated Skilled Admissions: 6 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Abbreviations: RN Registered Nurse SN Skilled Nurse LPN Licensed Practical Nurse POC Plan of Care HHA Home Health Aide SOC Start of Care MD Medical Doctor CM Clinical Manager QR 12/11/24 A2			

G0514	RN performs assessment 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 - ordered start of care date. Based on record review and interview, the home health agency failed to evidence documentation of an initial assessment visit for 2 of 3 active records reviewed of patients admitted in 2024 (Patients #2, #4). Findings include: 1. An agency policy titled “Client Admission Process,” last revised 12/12/17, indicated the admission process included an evaluation by an RN “to determine the immediate care and support needs of the client,” which was to be completed by an initial assessment visit. 2. Patient #2’s clinical record indicated a referral date of 6/27/24 for skilled nursing services. The agency obtained	G0514	**1. How are you going to correct thedeficiency?** **1a.** On **12/20/24**the Administrator provided CCMs with educated on the intake process and onthe need to retain all documentation obtained before and during the initialhome visit.	2024-12-30

	home health services on 9/06/24. RN 5 created and signed a plan of care on 9/06/24, pending insurance approval. Patient was admitted to the agency on 9/20/24. The record failed to evidence documentation of an initial assessment visit. During an interview with RN 4 and RN 5 on 11/26/24 beginning at 10:53 AM, RN 4 reported she and RN 5 conducted an initial "intake" assessment of Patient in-home prior to admission to the agency. The plan of care was then created based off identified needs from the initial assessment and other information obtained during the admission process. The nurses were unable to provide a date they performed Patient's initial assessment. 3. Patient #4's clinical record indicated Patient began receiving attendant care services from the agency on 8/17/23. The agency received a referral for skilled nursing and home health aide services on 1/05/24, and Patient's start of care for SN and HHA services was 1/23/24. The record failed		**1b.** On **12/20/2024**The Administrator updated the Referral/Intake form to include prompts toobtain pertinent information needed to determine eligibility for home healthservices and aid in the development of the Plan of Care. Items that were addedor updated are in red font. On **12/30/24** theAdministrator made an additional change to page 1, adding the InitialAssessment Visit Date next to Referral Date with the statement *"**Please note, initial assessment mustoccur within 48 hours of referral or dc from hospital or physician orderedstart of care date."* The statement is also on page 3, at the start of theIntake (Initial Assessment) section of the form. Education related to allchanges was provided to CCMs on **12/30/24.** **2. How are you going to prevent thisdeficiency from recurring in the future, even if already corrected?** **2a.** By including side-by-side spaces for theReferral Date and Initial Assessment Visit date on the Referral/Intake form,this will ensure compliance with	

	to evidence documentation of an initial assessment visit. During an interview with RN 5 on 12/02/24 beginning at 8:57 AM, she reported she was Patient's nurse case manager. RN 5 stated after receiving the referral for SN and HHA services, she conducted an initial assessment visit with Patient, which included a "focused" physical assessment. RN 5 reported she did not document the initial assessment visit, as care needs identified during the visit were noted on Patient's initial POC. 410 IAC 17-14-1(a)(1)(A)		completing the visit within 48-hours ofreferral or discharge home from the hospital, or on the physician ordered startof care date. **Starting 12/30/24** **2b.** Beginning **12/30/24**, copies of all documentation received from providersinvolved in the individual's care will be taken to the Initial AssessmentVisit. During the Initial Assessment visit, the CCM will review thedocumentation with the individual and/or their guardian/representative to comparethe information previously received with what is currently being done in thehome. Following the Initial Assessment Visit, the CCM will contact the PCP todiscuss any variances and obtain clarification orders to ensure the most up todate orders are available at start of care. **Initiated on 12/30/24** **2c.** 100% of Referral/Intake forms will beaudited prior to all admissions to ensure all necessary information hasbeen included and is timely in completion. **Starting12/20/24** **2d.** During the Referral/Intake auditprocess, proof of	

			coordination of care with the PCP will be evaluated to ensurethe most current and up to date information has been obtained. 100% of allReferral/Intake Forms will address coordination of care pre and post-InitialAssessment Visit. **Starting 12/30/24** The goal is toachieve 100% compliance, effective immediately. **3.Who is going to be responsible for #1 and #2?** **1a.** The Administrator developed education presented to CCMs. **1b.** The Referral/Intake form was updated by the Administrator. TheReferral/Intake Audit Form was developed/updated by the Administrator. **2a.** The Administrator is responsible for maintaining andupdating all forms. **2b.** CCMs are responsible for taking copies of documentation tothe Initial Assessment Visit to review. **2c.** CCMs and Administrator will	

			be responsible for all ongoingaudits of Referral/Intake forms. **2d.** The Administrator or another CCM will verifythat proof of coordination of care is in the chart **4.By what date are you going to have the deficiency corrected?** Correctionshave been made as of **12/30/24** Auditswill occur on an **ongoing** basis	
G0550	At discharge 484.55(d)(3) At discharge. Based on record review and interview, the home health agency failed to evidence documentation of the discharge comprehensive assessment for 1 of 1 closed record review of a patient discharged due to caregiver request (Patient #6). Findings include: 1. An agency policy titled "Client Discharge Process," last revised 11/28/19, indicated the	G0550	**1. How are you going to correct thedeficiency?** On **12/20/24** the Administrator provided educationto CCMs related to our Client Discharge Process (C-500) and the importance of athorough Discharge Chart Audit following a client discharge. On **12/20/24** The Administrator educatedCCMs on changes that were made to the Discharge Chart Audit form. On **12/30/24** the Administrator educatedCCMs on a new form,	2024-12-30

	discharge process included completing a discharge assessment. 2. Patient #6's clinical record included a discharge summary, dated 11/03/24, which indicated Patient was discharged from the agency effective 11/03/24 per caregiver request. The record failed to evidence documentation of a discharge comprehensive assessment. 3. During an interview with Clinical Manager and RN 4 on 12/02/24 beginning at 3:58 PM, the staff reported a discharge comprehensive assessment visit was conducted with Patient prior to discharge, however the staff was unsure of the date. When queried how the visit was documented, CM reported the agency had a discharge comprehensive assessment form, but she could not find documentation of the visit in Patient's record.		Pre-Discharge Audit Checklist. CCMs voiced understandingthat this audit will be completed 2-4 business days ***prior*** to a scheduled discharge. On **12/20/24** the Administrator reviewedthe Client Discharge Process with CCMs, reviewed the Discharge Chart Audit formwith CCMs. All CCMs signedoff on an Acknowledgement of Training Verification. **12/20/24** **2. How are you going to prevent thisdeficiency from recurring in the future, even if already corrected?** **2a.** Beginning **12/30/24**CCMs will utilize the Pre-Discharge Chart Audit Checklist 2-4 business daysprior to a scheduled discharge. **2b.** CCMs will complete the Pre-Discharge Audit form 2-4business days before 100% of all scheduled discharge assessments. Once thePre-Discharge Audit Checklist has been completed, the CCM can proceed with	

			signed form will be given to the individual who isperforming the official post Discharge Chart Audit. **New audit form was implemented on 12/30/24** **2c.** The Administrator or another CCM will utilize the updatedDischarge Chart Audit form for 100% client discharges. **Effective 12/20/24** Goal is to have100% compliance, effective immediately. **3. Who is going to be responsible for #1and #2?** **1.** The Administrator is responsible for development of formsand processes, as well as educating CCMs on all updates. **2a and 2b.** CCMs will perform Pre-Discharge AuditChecklists for all pending discharges 2 to 4 business days prior to thescheduled discharge to ensure adequate preparation. **2c.** CCMs and/or Administrator **4.By what date are you going to have the deficiency**	

			corrected? Corrections were made as of **12/30/24** Audits will continue on an **ongoing** basis	
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and	G0574	**1. How are you going to correct the deficiency?** 1a. Nursing Diagnosis with Intervention has been added to our Plan of Care template, it is under section 21 on page 3 *(see attached)*. **12/16/24** 1b. Nursing Diagnosiswith Nursing Interventions identified on Nursing Care Plan(s) have been addedto 100% of client Plan of Cares. Orders have been sent to PCP alerting them ofthe Nursing Diagnoses and Nursing Interventions. Signed orders placed in chartas they are returned. **Goal of having allorders sign, returned and in the chart by 01/03/25** **2. How are you going to prevent thisdeficiency from recurring in the future, even if already corrected?** **Phase 1:** Nursing Diagnosis and NursingInterventions have been	2025-01-03

	identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the home health agency failed to ensure the plan of care included all patient-specific interventions, for 5 of 5 complete active records reviewed (Patients #1, 2, 3, 4, 5). Findings include: 1. An agency policy titled "Nursing Care Plans Policy," last revised 1/11/18, indicated nursing care plans would be developed by an RN and would "correspond to the problems identified" during an initial assessment, services needed, and goals for the patient. The nursing care plans were to include "a list of specific interventions with plans for implementation." 2. Patient #1's clinical record included a plan of care for the current recertification period of 11/18/24 – 1/16/25. The plan of care indicated Patient was to receive skilled nursing services. The record included nursing		added to the Active Chart Audit form. **Phase 2:** Following the initial update to 100% ofall client Plan of Cares, HomePointe HealthCare will perform audits on ≥25%of all active charts every quarter, which will provide continued surveillanceof the updated item on the Plan of Care. **3. Who is going to be responsible for #1and #2?** 1a. TheAdministrator updated the Plan of Care template. 1b. TheAdministrator and CCMs sent orders to PCPs informing them of each client'sNursing Diagnosis and NursingInterventions. 2. Phase 1: The CCMs andAdministrator added Nursing Diagnoses and Interventions to all client Plan ofCares. 2. Phase 2: The CCMs are responsible for performing audits on 25% of all active charts each quarter.	

	"Infection [related to] COVID-19 Pandemic ... Alteration in Nutrition – Less Than Body Requirements ... Communication, Impaired ... Alteration in Cardiac Output ... Activity Intolerance ... Impaired Gas Exchange ... Caregiver Role Strain ... Newborn Care: Knowledge Deficit ... Safety ... Alteration in Comfort; Acute and Chronic Pain ... Mobility Impairment ... Skin Integrity Alteration ..." which indicated nursing interventions to be performed routinely and as needed during visits. The plan of care failed to evidence all patient-specific interventions to be performed by nursing staff as indicated on the nursing care plans. During an interview with RN 4 on 11/22/24 beginning at 11:45 AM, she reported she was Patient's nurse case manager. RN 4 stated the nursing interventions indicated on the nursing care plans were not included in the plan of care. 3. Patient #2's clinical record included a plan of care for the current recertification period of 11/20/24 -1/16/25. The plan of care indicated Patient was to			

	receive SN services. The record included nursing care plans for the problems of "Skin Integrity Alteration ... Alteration in Nutrition – Less Than Body Requirements ... Bowel Elimination – Diarrhea ... Safety ... Falls ..." which indicated nursing interventions to be performed routinely and as needed during visits. The POC failed to evidence all patient-specific interventions to be performed by nursing staff as indicated on the nursing care plans. 4. Patient #3's clinical record included a plan of care for the current recertification period of 10/18/24 – 12/16/24. The plan of care indicated Patient was to receive SN services. The record included nursing care plans for the problems of "Communication, Impaired ... Safety ... Alteration in Comfort; Acute and Chronic Pain ... Activity Intolerance ... Mobility Impairment ... Infection r/t COVID-19 Pandemic ... Skin Integrity Alteration ..." which indicated nursing interventions to be performed routinely and as needed during visits. The POC failed to evidence all			

	be performed by nursing staff as indicated on the nursing care plans. During an interview with Clinical Manager on 12/02/24 beginning at 2:51 PM, she reported she was Patient's nurse case manager. Clinical Manager reported all nursing interventions noted on Patient's nursing care plans were not included on the POC. 5. Patient #4's clinical record included a plan of care for the current recertification period of 11/18/24 – 1/16/25. The plan of care indicated Patient was to receive SN services. The record included nursing care plans for "Alteration in Comfort; Acute and Chronic Pain … Activity Intolerance … Caregiver Role Strain … Skin Integrity Alteration … Falls … Safety …" which indicated nursing interventions to be performed routinely and as needed during visits. The POC failed to evidence all patient-specific interventions to be performed by nursing staff as indicated on the nursing care plans. During an interview with RN 5 on 12/03/24 beginning at 8:57			

	AM, she reported she was Patient's nurse case manager. RN 5 reported all nursing interventions noted on Patient's nursing care plans were not included on the POC, as this was not the agency's process. 6. Patient #5's clinical record included a plan of care for the current recertification period of 11/22/24 – 1/20/25. The plan of care indicated Patient was to receive SN services. The record included nursing care plans for "Skin Integrity Alteration … Alteration in Comfort; Acute and Chronic Pain … Alteration in Nutrition – Less Than Body Requirements … Mobility Impairment … Safety … Infection … Caregiver Roll Strain … Activity Intolerance … Alteration in Cardiac Output …" which indicated nursing interventions to be performed routinely and as needed during visits. The POC failed to evidence all patient-specific interventions to be performed by nursing staff as indicated on the nursing care plans. During an interview with Clinical Manager on 12/04/24 beginning at 11:51 AM, she			

	case manager. Clinical Manager reported all nursing interventions included within Patient's nursing care plans were not included on the POC, as the POC was "physician driven."			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the home health agency failed to ensure all care and services were provided according to physician orders for 2 of 5 active records reviewed (Patient #2, 5). Findings include: 1. Patient #2's clinical record included a plan of care with a start of care date of 9/09/24, pending insurance approval. The plan of care indicated Patient was to receive skilled nursing services. Nursing interventions included "Ostomy [surgically created opening in abdominal wall] orders (poor seal, adaptive ring, pediatric bag): Dependent on surgery on	G0580	**1 Howare you going to correct the deficiency?** **1a** Education provided to all CCMs relatedto the updates made to the Referral/Intake form, signed TrainingAcknowledgement obtained and placed in each CCM's employee HR file **12/20/24**. CCMs voiced understanding inthe necessity to include specific care instructions when obtaining ordersduring the comprehensive assessment. **1b.**On **12/30/24**, additional education was provided to CCMs related to the PhysicianOrders Policy (C-635) and Coordination of Client Care Policy (C-360)(Procedure: C). During the in-service of these policies, the Administratorreviewed the regulatory requirement mandating that all medications,	2025-01-10

	to evidence further instructions on ostomy care to be provided by nursing staff. The record indicated Patient was admitted to the home health agency on 9/20/24. RN 4 and RN 5 conducted an admission comprehensive assessment and RN 3 conducted a SN visit on 9/20/24. RN 3 documented she changed Patient's ostomy appliance during the visit. The record failed to evidence physician orders for Patient's ostomy care were obtained prior to RN 3 changing Patient's ostomy appliance. During an interview with RN 3 on 11/25/24 beginning at 4:42 PM, she reported during her first visit with Patient on 9/20/24, RN 4 and RN 5 were working on the admission process, including creating the plan of care, while RN 3 was providing care to Patient. When queried how the nurse knew what tasks and interventions to perform, RN 3 reported care was provided according to Person A's, primary caregiver to Patient, instructions. During an interview with RN 4 and RN 5 on 11/26/24 beginning at 2:56 PM, RN 4		servicesand treatments be administered only as ordered by the physician. TheAdministrator provided instruction that care should be based on thecomprehensive assessment and directed by the attending physician The Administratoralso provided education related to the process of obtaining verbal orders, CCMsvoiced understanding of the need to obtain verbal orders during admission iffurther care instructions are needed. **1c** Education was developed for RNs andLPNs who provide hands on care. 100% of RNs and LPNs will receive educationrelated to the necessity for obtaining complete physician orders prior tonurses administering medication or performing any treatment or procedures. 100%of nursing staff will take and pass a test with a score of ≥80% nolater than **01/03/25** in order toprove competence in their knowledge to provide care only as ordered by aphysician.	

	reported the nurses did not obtain orders for Patient's ostomy care during the admission comprehensive assessment visit on 9/20/24. RN 4 reported ostomy care provided by RN 3 during the 9/20/24 visit would have been per Person A's instructions and/or hospital discharge instructions. The record failed to provide hospital discharge instructions with ostomy care orders dated prior to 9/20/24. The record included a physician order to check Patient's blood sugar twice a day. SN visit notes, signed by RN 2 and dated 11/08/24, 11/11/24, 11/12/24, and 11/15/24, failed to evidence Patient's blood sugar had been checked and documented twice a day according to physician's orders. During an interview with RN 2 on 11/25/24 beginning at 3:04 PM, she reported Patient's blood sugars were ordered to be checked twice a day, however Patient's blood sugars were being checked only once a day per Person A, primary caregiver for Patient #2. The record failed to evidence Person A's request nor physician orders		**2. How are you going to prevent thisdeficiency from recurring in the future, even if already corrected?** **2a** The Referral/Intake forms will beaudited prior to 100% of client admission using the Referral/Intake Form AuditTool. *(See Referral Intake Form AuditTool)* **Ongoing** **2b** Phase 1: Audit a minimum of 1 NurseFlow Sheet per nurse to ensure compliance with physician ordered care. **01/10/25** If the care documented on theNurse Flow Sheet does not match what was ordered by the physician the CCM willcontact the nurse to provide re-education on following physicians orders. **2c** Phase 2: Conduct random audits ofNursing Flow Sheets to ≥25% of all nurses per quarter. **Ongoing** Ourgoal is to reach 100% compliance, effective immediately **3. Who is going to be responsible for #1and #2?** **1a** Administrator	

	to decrease the frequency of blood sugar checks. 2. Patient #5's clinical record included a plan of care for the recertification period of 9/23/24 – 11/21/24 which indicated Patient was to receive SN services. Patient's services were placed on hold by the agency on 11/05/24 due to hospitalization. The record included a written physician order, dated 11/11/24 and signed by Clinical Manager, to resume home health services, effective 11/11/24. The record failed to evidence a signed written order nor verbal order to resume services had been obtained by the agency prior to resuming home health services. The record indicated skilled nursing visits were conducted on 11/13/24, 11/14/24, 11/15/24, 11/16/24, 11/20/24, 11/21/24, and 11/22/24 without physician orders. During an interview with Clinical Manager on 12/04/24 beginning at 11:51 AM, she reported when Patient was discharged from the hospital, CM called Patient's physician office and to notify the agency was resuming home health		**1b** Administrator **1c** Administrator **2a** Clinical Care Managers **2b** Clinical Care Managers and Administrator **2c** Clinical Care Managers andAdministrator **4.By what date are you going to have the deficiency corrected?** **1a** 12/20/24 **1b** 12/30/24 **1c** 01/03/25 **2a** Ongoing **2b** 01/10/25 **2c** Ongoing	

	services, then sent a written physician order for signature. CM stated she was unsure if the physician office staff she spoke with were licensed, and indicated a verbal order to resume care was not obtained. 410 IAC 17-13-1(a)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the home health agency failed to promptly alert the physician of changes in the patient's condition for 2 of 2 active records reviewed which evidenced a change in patient condition (Patients #1, 2) and failed to notify the physician of its inability to provide services as ordered for 1 of 4 active records reviewed with missed or shortened visits (Patient #3). Findings include: 1. An agency policy titled "Services Provided Policy," last	G0590	1 **How are you going to correct thedeficiency?** **1a** The Administrator developed education,which has been provided to 100% of staff on the requirement to report allchanges in condition or changes in the needs of the client to the primary carephysician and Clinical Care Manager. Communication must be documented in thepatient's record. **Education and test tobe completed by 01/03/25** **1b** On **12/20/24**the Administrator provided education to all Clinical Care Managers regardingthe Coordination of Client Care Policy (C-360) (Procedure Section: A) andServices Provided Policy (C-100) (Procedure Sections: A, G). CCMs voicedunderstanding of	2025-01-03

	agency would notify the patient's physician if scheduled visits were unable to be performed or rescheduled. 2. Patient #1's clinical record indicated Patient was to receive skilled nursing services. A SN visit note, dated 11/04/24 by LPN 3, indicated Patient had a rash to his/her hands, feet, nose, right cheek, and around the mouth. The record indicated LPN 3 suspected Patient had hand, foot, and mouth disease (a viral infection which causes a rash and/or sores). The record failed to evidence Patient's physician was notified of Patient's new rash. During an interview with LPN 3 on 11/26/24 beginning at 4:55 PM, she reported she was notified of the new rash by Patient's primary caregiver on 11/03/24. After the nurse conducted her visit with Patient on 11/04/24, she notified RN 4, Patient's nurse case manager, of the rash. LPN 3 reported she did not notify Patient's physician of the change in Patient's condition. During an interview with RN 4 and CM on 11/27/24 beginning		the requirements as described in the policy and signed theSurvey Training Acknowledgment. **1c** On **12/20/24**the Administrator provided education to administrative staff related to thenecessity to notify the physician of all missed visits. Educated administrativestaff on the need to notify the physician when a client's family requests touse waiver in place of prior authorization. The Administrator explained that theprior authorization hours are considered physician ordered parameters. 2 **How are you going to prevent this deficiencyfrom recurring in the future, even if already corrected?** **2a** Provide education related to therequirement for reporting Change in Condition to the PCP and CCM annuallyduring our Staff Annual Training. Following the education, each staff will takea test over the subject, a score of ≥80% must be achieved in order tobe considered competent. **2b Phase1:** Audit a minimum of	

	at 9:30 AM, CM reported the nurse conducting the SN visit was responsible for communicating a change in patient condition to the patient's physician. RN 4 reported she was unaware if LPN 3 or other staff notified Patient's physician of the new rash. 3. Patient #2's clinical record indicated Patient was to receive skilled nursing services. A SN visit note, dated 10/29/24 by RN 2, indicated Patient had a fever and potential seizure activity during the nurse's visit. The record failed to evidence Patient's physician was notified of the potential seizure activity. During an interview with RN 2 on 11/25/24 beginning at 3:04 PM, she reported during the 10/29/24 visit, Patient had "stiffened up" and "startled longer than normal." RN 2 reported she did not notify Patient's physician of the potential seizure activity. During an interview with RN 4 and Alternate Clinical Manager on 11/26/24 beginning at 10:53 AM, RN 4 reported she was Patient's nurse case manager.		for 100% of RNs and LPNsto monitor for documentation of change in condition. **Audits to be completed by 01/10/25** **2c Phase2:** Conduct random audits of Nurse Flow Sheets to ≥25% of allnurses per quarter. **Ongoing** **2d.** Client visit frequencies that areoutside of the ordered range will be discussed during our weekly Coordinationof Care Meeting. If a discrepancy is noted, the PCP will be contacted by theCCM who oversees the case to discuss the variance and to receive orders asindicated. 3 **Who is going to be responsible for #1and #2?** **1a.** The Administrator. **1b**. The Administrator. **1c.** The Administrator. **2a.** CCMs and/or Administrator will ensureeducation is completed annually. **2b.** CCMs and Administrator will complete theNurse Flow Sheet audits **2c.** CCMs and Administrator will	

	RN 4 stated Patient had a previous diagnosis of a seizure disorder from when he/she was "younger," but the nurse was unaware of Patient having any seizures since beginning care with the agency on 9/20/24. Alternate Clinical Manager stated RN 2 should have notified Patient's physician of the potential seizure activity on 10/29/24. 4. Patient #3's clinical record indicated Patient was to receive skilled nursing services, with visits to be 10-13 hours per day, 4-5 days per week, with 1 additional day per week for 5-8 hours. The record indicated SN visits conducted on 10/04/24, 10/11/24, 10/18/24, 10/25/24, 11/01/24, 11/08/24, and 11/15/24 did not meet the minimum ordered duration of visits. The record failed to evidence Patient's physician was notified of the shortened visits. During an interview with Clinical Manager on 12/02/24 beginning at 2:51 PM, she reported she was Patient's nurse case manager. CM stated Administrative Assistant 1 was responsible for notifying the		complete25% of Nurse Flow Sheet Audits each quarter ongoing **2d.** CCM in conjunction with the StaffingCoordinator 4 **By what date are you going to have thedeficiency corrected?** Correctionswill be completed as of 01/03/25 100% of Nurses will have a minimum of 1 Flow Sheet Audited by 01/10/25 Ongoingmonitoring to take place with quarterly audits of Nurse Flow Sheets Ongoingmonitoring of client visit frequencies	

	shortened visits. During an interview with Administrative Assistant 1 on 12/02/24 beginning at 2:57 PM, she reported she was unable to find evidence of physician notification regarding Patient's shortened visits for the requested dates. 410 IAC 17-13-1(a)(2)			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the home health agency failed to coordinate care with all outside entities providing home health services to 1 of 1 active record reviewed of a patient receiving home health services from an outside entity (Patient #2). Findings include: 1. Patient #2's clinical record indicated a start of care date of 9/20/24. The record included a plan of care for the	G0606	1 **How are you going to correct thedeficiency?** **1a** Provided education to 100% of employeeson the necessity and importance for Coordination of Care. All staff will betested on their knowledge following the education, 100% of staff must score ≥80%.**Education must be completed by 01/03/25** **1b** The Administrator provided education toCCMs on the requirements for coordination of care as outlined in theCoordination of Client Care Policy (C-360). **12/20/24** **1c** The Administrator updated theReferral/Intake form to include a more comprehensive	2025-01-03

	recertification period of 11/20/24 – 1/18/25. The POC indicated Patient was to have Total Parental Nutrition (TPN, a method of providing nutrition) administered thru a central line (a long IV placed into a large vein). The POC failed to evidence who was responsible for monitoring and changing Patient's central line dressing. During an interview with Alternate Clinical Manager and RN 4 on 11/26/24 beginning at 10:53 AM, RN 4 reported she was Patient's nurse case manager. RN 4 stated Patient's central line was managed and dressing changes performed by Entity F, a home health agency. When queried how the agency coordinated care with Entity F, RN 4 reported she was unsure. Alternate Clinical Manager reported the agency should coordinate care with all agencies involved in a patient's care by sending POCs to the other agency(ies). Later in the interview, RN 4 stated Person A, primary caregiver for Patient, had reported via text message that Entity D, a home health agency, was monitoring and changing Patient's central line dressing once a week, as well as		educatedCCMs on the updates. **12/30/24** **2 Howare you going to prevent this deficiency from recurring in the future, even ifalready corrected?** **2a** Prior to Admission: The Referral/IntakeForm has been updated to include a space to list other providers involved inthe client's care *(See page 3)*. **2b** During the Initial Assessment Visit theCCM will review all providers involved in care and list their name, specialty,contact number and any notes on page 3 of the Referral/Intake form. **2c.** During Admission: CCM will review theprovider list with the client and/or guardian/representative to ensure that thelist is complete. **2d** After Admission: The completed Referral/Intakeform will be used to create the Provider Information form, which is located insection 1 of the client chart. **2e.** At each Supervisory Visit the CCM willreview the Provider List with the client and/or their	

	drawing blood work. During an interview with Person E, an employee of Entity F, on 11/26/24 beginning at 9:59 AM, he/she reported Patient had not received home health services from Entity F. Person E also stated Entity F did not service the county where Patient resided. During an interview with Person B, an employee of Entity C, a pharmacy, on 11/26/24 beginning at 10:40 AM, he/she confirmed the entity provided pharmacy services to Patient, which included preparing TPN. Person B stated per Entity C's records, Patient's central line was monitored and dressing changes performed by Entity D. 410 IAC 17-12-2(h)		guardian/representativeto ensure it is accurate and complete. Coordination of Care will be performedwith all providers involved in care. **3 Whois going to be responsible for #1 and #2?** **1a**. The Administrator developed staff education. **1b**. The Administrator **1c.** The Administrator updated theReferral/Intake form. **2a.** The Administrator completed the updatesto the form **2b.** CCMs are responsible for obtainingprovider information during the Initial Assessment Visit **2c.** CCMs are responsible for verifyingaccuracy during the admission. **2d.** Administrator and/or another CCM **2e.** The CCM **4 Bywhat date are you going to have the deficiency corrected?**	

			Educationwill be completed by 01/03/25 Allprocesses have been adopted as of 12/30/24 and are ongoing	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, policy review, and interview, the home health agency failed to ensure all staff followed standard precautions and agency policies/procedures for 2 of 3 home visit observations (Patients #2, 3). Findings include: 1. An agency policy titled "Standard Precautions Policy," last reviewed 3/01/24, indicated when washing hands, staff should apply soap, rub hands "vigorously" for at least 30 seconds, then rinse off the soap. 2. An agency nurse competency form, titled "Central Line TPN Line Medication Administration	G0682	**1 Howare you going to correct the deficiency?** **1a** Detailed education provided to 100% of staff related tohand hygiene and the process for disinfecting surfaces. **01/03/25** **1b** The Administrator and Alternate Administrator updated thecompetencies for Central Line Cap Change Flush and Central Line TPN Administrationand Flush to include greater detail of the process, including the amount oftime to clean surfaces. 100% of Registered Nurses were educated on the updatedcompetencies; all RNs working with clients who receive Central Line care werere-evaluated to demonstrate competency using the updated procedure **12/20/24**. **2 Howare you going to prevent this deficiency from recurring in the future, even**	2025-01-03

	and Flush Competency Evaluation," indicated prior to preparing Total Parental Nutrition (TPN, a method of providing nutrition thru a central line), staff should apply disinfectant to the intended workstation. 3. The review of manufacturer's instructions for Clorox disinfectant wipes, obtained 11/22/24 from www.clorox.com, indicated when using the wipe to disinfect, the surface should remain "visibly wet" for 4 minutes and should be allowed to dry.		**ifalready corrected?** **2a Hand Hygiene:** CCMswill observe employees perform Hand Hygiene at supervisory visits and promptlycorrect any variance from our policy. **2b** TheHand and Glove Hygiene competency will continue to be demonstrated by eachemployee, every year during our annual training sessions. **Ongoing** **2c Central Line:** All RNs who work with individuals whohave a central line will receive competency evaluations a minimum of annually. CCMsevaluate for competency. **2d** Additionally, RNs working with individuals who have acentral line will be evaluated for infection control practices at eachsupervisory visit. All evaluations will be conducted by the CCM and theprocedure demonstrated will be documented on the Supervisory Visit form and/oron a Competency Evaluation form when appropriate. **Ongoing** **3 Whois going to be responsible for #1 and #2?**	

	4. During a home visit observation with Patient #2 on 11/22/24 beginning at 3:35 PM, RN 2 was observed preparing to administer Patient's TPN. The nurse removed the TPN bag and holding case from a desk, cleaned the desk surface with a Clorox disinfectant wipe, then immediately placed the TPN bag, holding case, and other supplies onto the wet desk surface. After preparing the TPN, RN 2 went to Patient's bedside. The nurse scrubbed the connection hub of Patient's central line for 10 seconds, then connected a saline flush syringe. During an interview with RN 2 on 11/25/24 beginning at 3:04 PM, she reported on 11/22/24 she cleaned the desk surface with a Clorox wipe prior to preparing the TPN. The nurse was unsure of the dry time for the Clorox wipe, and could not recall if she allowed the desk surface to dry prior to returning items and beginning TPN preparation procedures. RN 2 stated the connection hub of a central lines should be scrubbed with an alcohol wipe for 15 seconds prior to connecting the saline syringe.		**1a.** The education was developed by the Administrator **1b.** Updates to the Central Line Cap Change Flush and CentralLine TPN Administration and Flush competencies were made by the Administratorand Alternate Administrator **2a** .CCMs **2b.** CCMs and Administrator **2c** CCMs and Administrator **2d** CCMs **4 Bywhat date are you going to have the deficiency corrected?** **1a** 01/03/25 **1b** 12/20/24 **2a through 2d:**Ongoing evaluations	

	During an interview with administrative staff on 11/25/24 beginning at 4:21 PM, Alternate Clinical Supervisor reported it would be "ideal" for staff to allow a surface wiped with a disinfectant wipe to dry prior to continuing with TPN preparation procedures. The administrative staff was unsure of the dry time of Clorox wipes. RN 4, nurse case manager for Patient #2, reported staff should scrub the hub of a central line for 30 seconds prior to connecting a syringe or tubing. 5. During a home visit observation with Patient #3 on 11/25/24 beginning at 8:58 AM. During the visit, LPN 1 was observed washing her hands prior to preparing and administering medications. The nurse scrubbed her hands outside of running water for 8 seconds, then scrubbed for the remaining time under running water. Soap was not observed on the nurse's hands while she scrubbed under running water. During an interview with LPN 1 on 11/25/24, she reported when washing her hands, she would scrub for "15-20" seconds outside of running water, then			

	repeat under running water. 410 IAC 17-12-1(m)			
G0686	Infection control education 484.70(c) Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). Based on record review, agency nurse competency review, complaint log review, and interview, the home health agency failed to re-educate staff when a breach in infection control procedures was reported for 1 of 1 record reviewed of a patient with a central line (Patient #2). Findings include: 1. An agency nurse competency form, titled "Central Line TPN Line Medication Administration and Flush Competency Evaluation," indicated prior to priming the IV tubing for Total Parental Nutrition (TPN, a method of providing nutrition thru a central line), staff should perform hand hygiene and apply non-sterile gloves. 2. An agency grievance form	G0686	**1. How are you going to correct thedeficiency?** Detailededucation was given to CCMs in written form related to the process ofre-educating staff when a breach of infection control during a procedure hasbeen reported. CCMs signed a training verification acknowledging understandingof the process. **12/20/24** Staffmembers who work with individuals who have a central line demonstratedcompetency through competency evaluation checkoffs for Central Line Cap ChangeFlush and Central Line TPN Administration and Flush. **12/20/24** **2. How are you going to prevent thisdeficiency from recurring in the future, even if already corrected?**	2024-12-20

	by RN 4, nurse case manager for Patient #2, indicated Person A, primary caregiver to Patient #2 and Patient #8, had notified RN 4 on 10/11/24 of RN 3's potential breach in infection control procedures. The note indicated while RN 2 and Person A were priming Patient #2's TPN tubing, RN 3 "came up and grabbed the end cap of the tubing for the TPN out of [Person A's] hand. [Person A] was upset because [he/she] said [RN 3] did not have gloves on" while priming Patient #2's TPN tubing. RN 4 documented she and Clinical Manager spoke with RN 3 regarding the alleged incident. RN 3 reportedly stated the priming of TPN tubing did not require a sterile setting and "nowhere [the nurse] touched was being contaminated …." The complaint documentation failed to evidence the agency re-educated RN 3 on agency infection control procedures for priming TPN tubing. 3. Patient #2's clinical record included a plan of care for the initial certification period of 9/20/24 – 11/19/24, which indicated Patient was to receive skilled nursing services. The POC indicated Patient had a		To ensureongoing compliance with infection control related to central line care, allstaff who work with individuals who have a central line will demonstratecompetency on an annual basis. **3. Who is going to be responsible for #1and #2?** 1. CompetencyEvaluations for Central Line Cap Change Flush and Central Line TPNAdministration and Flush were updated by the Administrator. 2. Ongoingeducation and competency evaluation will be assessed by the CCMs and/or theAdministrator.	

	central line (a long IV placed into a large vein) thru which staff were to administer TPN. The record indicated RN 2 conducted a SN visit on 10/11/24 from 8:30 AM – 4:30 PM, during which the nurse changed Patient's TPN bag. Patient #8's clinical record indicated Patient was to receive SN services, and Patient resided in the same location as Patient #2. The record indicated RN 3 conducted a SN visit with Patient #8 on 10/11/24 from 8:30 AM – 4:30 PM. During an interview with Person A on 11/22/24 beginning at 4:41 PM, he/she reported on 10/11/24, while RN 2 and Person A were priming Patient's new TPN tubing, RN 3 removed the tubing end cap without performing hand hygiene and donning gloves. Person A stated he/she had previously been trained to perform hand hygiene then wear gloves when priming TPN tubing, including when removing the tubing's end cap. Person A stated he/she reported the breach in infection control procedures to RN 4. During an interview with RN 2			

	on 11/25/24 beginning at 3:04 PM, she reported on 10/11/24, she observed RN 3 failing to wear gloves when priming TPN tubing. RN 2 reported she observed Person A report the breach in infection control procedures to RN 4. During an interview with RN 3 on 11/25/24 beginning at 4:42 PM, she reported on 10/11/24, while caring for Patient #8, she observed RN 2 and Person A priming Patient #2's TPN tubing with the tubing end cap on. RN 3 reported the end cap of the TPN tubing needed to be removed in order for it to prime correctly, so she removed the cap. Person A reportedly told RN 3 this was a breach in infection control procedures, as hand hygiene should be performed and gloves worn prior to touching the tubing end cap. RN 3 was unable to recall if she had performed hand hygiene prior to removing the cap, and reported she did not wear gloves. The nurse stated when priming TPN tubing, she was to perform hand hygiene, but gloves were not required for this procedure. RN 3 reported she spoke with RN 4 and CM regarding the			

	incident but had not received any re-education on agency procedures for priming TPN tubing. During an interview with RN 4 and CM on 11/26/24 beginning at 10:53 AM, the staff reported they spoke with Person A and RN 3 regarding the reported incident and had not identified any breaches in infection control procedures. The staff stated they had not performed any re-education with RN 3 regarding TPN priming procedures.			
G0818	HH aide supervision elements 484.80(h)(4)(i-vi) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's	G0818	**1. How are you going to correct thedeficiency?** Provideeducation over the Home Health Aide Supervision Policy to all CCMs. Educate HHA5 on the HHA Care Plan and Plan of Care. **12/20/24** **2. How are you going to prevent thisdeficiency from recurring in the future, even if already corrected?** Audit 100% ofHHA 5's HHA Daily Records for compliance until she has 1 month without errors. Once she reaches compliance, her Daily Records	2024-12-20

	condition; and (vi) Honoring patient rights. Based on record review and interview, the home health agency failed to supervise all HHAs to ensure the aide completed all tasks according to the aide care plan for 1 of 1 complete active record review of a patient receiving HHA services (Patient #4). Findings include: 1. Patient #4's clinical record indicated Patient was to receive home health aide services. The record included an aide care plan which indicated tasks the aide was to perform at each visit included but were not limited to obtaining Patient's temperature, pulse, and blood pressure; assisting with personal care, dressing, hair care, skin care, oral and gum care, elimination, and perineal care (cleaning the genital and rectal areas); checking pressure areas, medication reminders, transfer assistance, positioning, and meal preparation. The aide was also to assist Patient with showering and shampooing their hair "weekly." The record indicated HHA 5 conducted an HHA visit on		will continue to be audited a minimum of monthly. **3. Who is going to be responsible for #1and #2?** 1. TheAdministrator developed the education. 2. CCMs areresponsible for auditing HHA #5's Daily Records.	

	aide visit for the week of 10/14/24 – 10/20/24. The visit flowsheet failed to evidence HHA 5 completed all tasks according to the aide care plan. The record indicated RN 5 conducted an HHA Supervisory Visit of HHA 5 on 10/15/24. The aide was not present for the visit. The supervisory visit note indicated HHA 5 had not "completed appropriate records in compliance with [the agency's] policies and procedures ... followed the client's plan of care for the completion of tasks assigned ...." The record indicated HHA 5 conducted an HHA visit on 10/21/24, which was the only aide visit for the week of 10/21/24 – 10/27/24. The visit flowsheet failed to evidence HHA 5 completed all tasks according to the aide care plan. The record failed to evidence RN 5 followed up with HHA 5 regarding the aide's continued failure to complete all tasks according to the aide care plan. During an interview with RN 5 on 12/03/24 beginning at 8:57 AM, she reported after the			

	10/15/24 aide supervisory visit, she discussed with HHA 5 how to document tasks performed. The nurse did not perform an in-person supervisory visit with Patient #4 and HHA 5 to ensure all tasks were performed according to the aide care plan. RN 5 reported that HHA 5's documentation was "better" on 10/21/24, and the aide had documented that she had completed more, but not all, of the assigned tasks per the care plan. The nurse stated she had multiple follow-up conversations with HHA 5 regarding the requirements for following the aide care plan and documentation, however she was unable to provide documentation of these conversations. 410 IAC 17-14-1(n)			
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: 11/21/24,	N0000		

	11/22/24, 11/25/24, 11/26/24, 11/27/24, 12/02/24, 12/03/24, 12/04/2024 12-month Unduplicated Skilled Admissions: 6			
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 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:	N9999	**1 Howare you going to correct the deficiency?** ProvideHome Health Aides who work with an individual who receives enteral feedingswith detailed education related to IC 16-27-1.5-6, Conditions Required toAdminister Gastrointestinal and Jejunostomy Tube Feedings. In addition to theeducation, a map identifying all locations where the proctored exam can beaccessed. **01/03/25** **2 Howare you going to prevent this deficiency from recurring in the future, even ifalready corrected?** **2a** CCMs will conduct intermittent, unannounced visits to thehome of clients who receive tube feeding and home health aide services. The CCMwill observe firsthand how tube feedings are being administered. 50% of all HHAswho provide care to an	2025-01-10

(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.

(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

individual who receives tube feeding during the HHAshift will receive an unannounced visit each quarter. **Initiated 12/30/24, Ongoing**

2b Assist the HHA (parent working as a HHA with their child)to develop a plan for how tube feeding will be handled during their shift. Willit be administered by an alternate caregiver or will the HHA clock out toadminister the tube feeding? If those two options are not feasible, it may benecessary to include the PCP to discuss if the individual would benefit from askilled nurse providing a visit to administer the tube feeding. Document theplan in the clients Plan of Care.

2c At every supervisory visit, ask the HHA "how is the tubefeeding accommodation working? Are any changes needed?" Document their answeron the Supervisory Visit form.

2d CCM or Administrator to encourage the HHA to accept thetube feeding education, let them know that the CCM or Administrator will be theone

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 feedings to the registered home health aide 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

providing the education. Document that tube feeding education was discussedon the HHA Supervisory Visit form. Once the education has been complete, assistthe HHA with making arrangements to take the proctored exam at one of the IvyTech testing sites identified on the map.

3 Whois going to be responsible for #1 and #2?

1. Education developed by the Administrator.

2a. CCMs

2b. The Administrator updated the HHA Supervisory Visit form

2c. The CCMs are responsible for assisting HHAs withestablishing a plan for accommodating the tube feedings that are scheduledduring the shift.

2d. CCMs and the Administrator are responsible for providingthe tube feeding education and assisting the HHA with scheduling the proctoredexam.

4 Whenwill the corrections be made

1. Educationmust be

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 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

completed by 01/03/25

2a. Ongoing unannounced visits

2b. 01/10/25

2c. Ongoing until certification has beenobtained

2d. Ongoing until certification has beenobtained

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, personnel file review, and interview, the home health agency failed to ensure the home health aide had completed the required training prior to administering gastrointestinal tube feeding for 1 of 4 records reviewed of a patient receiving HHA services and not allowed any oral feedings (Patient #9).

Findings include:

1. Patient #9's clinical record included a plan of care for the recertification period of 11/06/24 – 1/04/25, which indicated Patient was to receive HHA services. Patient was to receive nutrition through a

	times a day. The POC indicated the aide "may provide meal prep and administer [G-tube] feedings if certified." The record included an aide care plan which indicated daily aide tasks included but were not limited to "meal preparation." The record included aide visit notes, completed by HHA 1 and dated 10/28/24, 10/29/24, 10/30/24, 10/31/24, 11/01/24, 11/02/24, 11/03/24, 11/04/24, 11/05/24, 11/06/24, 11/07/24, 11/08/24, 11/09/24, and 11/18/24, which indicated HHA 1 completed the task of "meal preparation." The review of HHA's personnel file failed to evidence the aide had completed all required training required to administer G-tube feedings. During an interview with HHA 1 on 11/27/24 beginning at 1:41 PM, when queried what the aide did for the task of "meal preparation" for Patient's visits, the aide reported he gave Patient his/her tube feeding. During an interview with RN 5 on 11/27/24 beginning at 2:02 PM, when queried what HHA 1 was to do for the task of "meal			

	visits, the nurse reported the aide was to prepare the tube feeding, but was not to administer the feeding, as he had not completed all required HHA training.			

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
Amanda L. Musser	Administrator	12/31/2024 2:48:33 PM