STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157570	A. BUILDING B. WING	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Total Home Health Services Inc	770 N MAIN STREET, CROWN POINT, IN, 46307

(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: December 3, 4, 5, and 6, 2024 Active Census: 77 During this Emergency Preparedness survey, Total Home Health Services, Inc. was found to be in compliance with the Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers at 42 CFR at 42 CFR 484.102.	E0000		
G0000	INITIAL COMMENTS	G0000		

	This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Agency. Survey dates: December 3, 4, 5, and 6, 2024 12 Month Unduplicated Skilled Census: 315			

	This deficiency report reflects State Findings cited in accordance with 410 IAC 17. A1 12/17/2024 Abbreviations used in report: Home Health Aide [HHA], Director of Nursing [DON], Clinical Supervisor [CS], Registered Nurse [RN], Plan of Care [POC], Start of Care [SOC], Occupational Therapist [OT], Skilled Nurse [SN], Physical Therapist [PT], Certified Occupational Therapy Assistant [COTA], and centimeters [cm].			
G0374	Accuracy of encoded OASIS data 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on record review and interview, the agency failed to ensure Outcome and Assessment Information Set (OASIS) accurately reflected the patient's status at the time of assessment in 1 of 2 active clinical records reviewed with a staged wound and a home visit (Patient #2).	G0374	1. How the deficiency will be or has beenimmediately corrected. As it relates to patient #2, the agency isunable to modify the cited OASIS currently. The patient is receiving appropriatewound care per physician orders currently. The agency will ensure the accuracyof patient # 2's future OASIS as it relates to wounds and wound care. The Agency Administratorand Clinical Manager met with the	2025-01-02

	Findings include: The clinical record of Patient #2 included an initial comprehensive assessment completed on 10/11/2024 by RN 2. The primary diagnosis was a stage 2 pressure ulcer (partial thickness open wound where skin wears away) wound of the right buttock, and a secondary diagnosis included a stage 2 pressure ulcer of the left buttock. The wound care documentation of the comprehensive assessment included a stage 2 left buttock pressure ulcer that measured 3.4 cm long X 3.5 cm wide X .2 cm in depth and stage 2 right buttock pressure ulcer that measured 3 cm long X 4.5 cm wide X .2 cm deep. OASIS documentation at M1324 asked the stage of the most problematic unhealth pressure ulcer /injury that is stageable; the M1324 failed to evidence documentation of staged pressure ulcers, documentation was N/A (not applicable). During an interview on 12/05/2024 beginning at 12:30 PM, RN 2 relayed the reason for home health for Patient was due to pressure ulcers on the		12/23/24 to discussthe survey findings and the need for thorough review of all submitted OASISdocumentation. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur. The agencywill conduct mandatory in-service training for all clinical staff on properOASIS documentation, focusing on accuracy, completeness, and the importance of assessmentin care planning. Initial in-service date is scheduled for January 2nd, 2025 The Quality Assuranceteam will review 100% of all submitted OASIS documentation for accuracy andcompleteness. In the event an OASIS assessment appears incomplete orinconsistent with other available collaboration, the QA team will confer withthe assessing clinician and request revisions as appropriate. This 100%auditing will be ongoing. If the quality assurance review	

	right and left buttock. During an interview on 12/06/2024 beginning at 8:10 AM, Other D, family member and caregiver for Patient #2, revealed Patient had a pressure ulcer on both the right and left buttock at the start of care with the agency.		team identifiestrends in a specific clinician's assessment documentation, the qualityassurance review team will provide additional one-on-one education tothat clinician. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. Clinical Manageror designee	
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and	G0434	1. How the deficiency will be or has beenimmediately corrected. On 12/4/24 the Administrator immediately scanned the agencyadmission service agreement and attached to patients electronic medical record. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur. The Administrator has developed a tracking spreadsheet foradmission paperwork which will be reviewed weekly by	2025-01-02

	interview, the agency failed to ensure the rights of the patients including consent in advance of and during treatment in 1 of 1 active clinical record review with a start of care on or after 11/23/2024 (Patient #1). Findings include: The clinical record for Patient #1 included an initial comprehensive assessment, completed on 11/23/2024, and a POC for the certification period 11/23/2024 to 01/21/2025 with ordered services SN, PT, and OT throughout the certification period. A PT and OT evaluation were completed on 11/27/2024 and an SN visit was completed 11/25/2024 that included wound care. The clinical record failed to evidence a consent for treatment from the start of care date 11/23/2024 to 12/04/2024. During the entrance conference 12/03/2024 beginning at 11:00 AM, Administrator relayed the clinical records are completely electronic and any written documents were scanned into EMR, then shredded. During an interview on 12/04/2024 beginning at 12:15 PM, Administrator relayed the		Administrator ordesignee. In the event the agency identifies an additionalnoncompliance agency will initiate a performance improvement plan to addressthe concern. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. Administrator or designee	

	consent documentation had not been scanned into the electronic medical record and was not available for review. 410 AC 17-12-3(b)(2)(D)(i)(AA)			
G0458	Outcomes/goals have been achieved 484.50(d)(3) The transfer or discharge is appropriate because the physician or allowed practitioner, who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with §484.60(a)(2)(xiv) have been achieved, and the HHA and the physician or allowed practitioner, who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services; Based on record review and interview, the agency failed to evidence the discharge was appropriate and the allowed practitioner, responsible for the home health plan of care, agreed that the patient no longer needed the services set forth in the plan of care for 1 of 1 discharged record reviewed for goals met. (Patient 9) The Findings Include: The record reviewed on 12/5/24 for Patient 9 included a discharge comprehensive	G0458	1. How the deficiency will be or has beenimmediately corrected. As it relates to patients #9 a corrected DC summary was sentto physician requesting signature & date. Additionally, an order of correction waswritten informing the physician that all goals were met. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur. On 12/9/24 the agency revised their process of requesting DCinstructions\orders when a patient has not met frequency or goals prior to discharging.Additionally, the agency is committed to requesting physician date and signatureof all DC summaries in the event the patient has not met all goals prior	2025-01-02

	assessment, dated 8/23/24, indicated Patient was discharged with goals met. The discharge summary dated 9/5/24 indicated 6 of the 14 physical therapy goals were not met. During an interview on 12/6/24 beginning at 1:00 PM, the clinical manager indicated Patient was discharged with goals met and that the PT made an error in documentation. The clinical manager was unable to provide the order for discharge. No further documentation was provided prior to survey exit.		todischarging. As part of the agency QAPI program, Clinical Manager ordesignee will review 100 % of DC charts to ensure compliance with this above procedure.In the event the agency identifies noncompliance a performance improvement planwill be initiated. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. Administratoror designee	
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 agency failed to ensure a registered nurse conducted an initial assessment visit to determine the	G0514	1. How the deficiency will be or has beenimmediately corrected. The Administrator and Clinical Manager spoke with RN case manager toinvestigate why patient wasn't seen within 48 hours of referral. RN case manager stated the delay was due topatient and spouse request. Late entrycommunication note, and verbal order were written and sent to physician forsignature. 2. How the deficiency will be prevented fromrecurring i.e.	2025-01-02

	immediate care and support needs of the patient within 48 hours of referral for 1 of 1 active records reviewed that included a recertification period. (Patient #6) The Findings Include: The record reviewed on 12/5/24 for Patient 6 included a referral dated 5/31/24. The record included a start of care comprehensive assessment dated 6/6/24. During an interview on 12/6/24 beginning at 11:50 AM, the administrator indicated they did not know why there was a delay and there was no documentation related to the delay.		measure put into place or systematic changes made to ensure thedeficiency will not recur.	

			The agencywill conduct mandatory Inservice training for all clinical staff on 1/2/25 on theimportance and necessity of performing an initial assessment visit within 48hours of referral or within 48 hours of patients return home. The agency re-educated all clinical staff onagency policy "5-B Initial Assessment" to include: The initial visit shall be made within 48 hours of referralacceptance from a physician or from discharge from an inpatient facility, or onthe physician-ordered start of care date. If the initial visit is delayed forreasons such as an inability to contact the patient or at the patient'srequest, the physician shall be notified, and documentation shall be completedreflecting the physician's approval of the patient's request for the delay. Ifthe physician specifies a specific start of care date or authorizes a dategreater than 48 hours, the plan of care or a separate verbal order shallspecify this. As part of ourQAPI program Clinical manager or designee will conduct an audit on all	

			ensure compliance of SOC being completed within 48 hours ora verbal order written to notify physician. In the event, there is furthernoncompliance the agency will expand the audit scope and open a performanceimprovement plan for this issue. 3.Who isresponsible to ensure the deficiency will be/has been corrected and compliancemaintained at 100%. Clinical Manageror designee	
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the comprehensive assessment failed evidence a review of all medications the patient was currently using, to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects	G0536	1. How the deficiency will be or has beenimmediately corrected. As it relates to patient #1, #2, #5 and #6 drug interactionswere faxed to physician with fax confirmation received as of 1/2/25. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur. Agency has amendedpolicy "5-D Drugs & Biologicals" to include the following:	2025-01-02

	and or drug interactions, duplicate drug therapy, and noncompliance in 4 of 4 active records reviewed with severe drug-drug interactions (Patient #1, 2, 5, and 6). Findings Include: 3.The record reviewed on 12/4/24 for Patient 5 included a start of care comprehensive assessment dated 11/19/24 which indicated medications were reconciled with serious interactions. The record failed to evidence notification to the provider of the major drug-drug interaction between Diltiazem (a medication used to treat high blood pressure and Atorvastatin (a medication used to treat high cholesterol). During an interview on 12/4/24 beginning at 2:40 PM, the Clinical Supervisor (CS) indicated the drug-drug interaction report had not been completed and therefore was not sent to the provider for notification. 4.The record reviewed on 12/5/24 for Patient 6 included a recertification comprehensive assessment dated 11/29/24 which indicated medications		*information shall be recorded in the patients record andreported to the physician as a major drug interaction*. Clinical Manager or designee will send the major drug todrug interaction report to the primary care provider at the time of thecompletion of the comprehensive assessment. Clinical Manager or designee will review completedcomprehensive assessments daily and major drug to drug interaction reports willbe faxed to the provider. As part of the agency QAPI program agency will add review oftimely submission of major drug interactions at time of comprehensiveassessment. If further noncompliancepersists the agency will add a performance improvement plan. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. ClinicalManager or designee	

were reconciled with serious interactions. The record failed to evidence notification to the provider of the major drug-drug interaction between Amiodarone (a medication used to treat irregular heartbeat) and Beta-Adrenergic Blockers (a medication used to treat high blood pressure and irregular heartbeat).

During an interview on 12/6/24 beginning at 11:50 AM, the clinical supervisor indicated they do not send the drug-drug interaction report to the provider, at the time of the comprehensive assessment. The CS relayed they send the interaction report with the plan of care, regardless of interaction level. The administrator indicated record did not include documentation that the provider was notified of the drug-drug interaction.

1.The clinical record of Patient #1 revealed an initial comprehensive assessment, dated 11/23/2024, indicated the medications were reconciled and no issues were found during the review. Patient's medications included: Breo

	Ipratropium-Albuterol, Lasix, Lorazepam, Lyrica, Metoprolol, MiraLAX, Oxcarbazepine, Oxygen, Pantoprazole, Potassium Chloride, Prednisone, Prozac, Pulmicort, Singulair, Spironolactone, Theophylline, Tramadol, and Trazodone. The medication interaction report on the electronic medical record [EMR] revealed major interactions between the following: Lorazepam and Tramadol, Tramadol and Lyrica, Lorazepam and Tramadol, Prozac and Tramadol, Trazodone and Tramadol, Prozac and Trazadone, and Potassium and Spironolactone. The clinical record failed to evidence physician notification of major drug interactions within Patient's home medication list. During an interview on 12/04/2024 beginning at 12:15 PM, Clinical Manager relayed the major medication interactions were not provided to the physician. 2.The clinical record of Patient #2 revealed an initial comprehensive assessment,			

	Patient's medication list included Omeprazole and Plavix. The EMR drug interaction report identified a major drug interaction between Plavix and Omeprazole. The clinical record failed to evidence the drug interaction report, from the comprehensive assessment at start of care dated 10/11/2024, was provided to Patient's primary care physician until 11/05/2024. During an interview on 12/04/2024 beginning at 12:25 PM, Clinical Manager relayed the medications interactions were usually sent to the physician with the plan of care.			
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on record review and interview, the agency failed to ensure the comprehensive assessment was updated and	G0544	1. How the deficiency will be or has beenimmediately corrected. As it relates to patient #2 Clinical manager provided one onone education with RN #2 on the need to perform a comprehensive assessment dueto a major decline or improvement in patients' health. On 12/6/24 an updated comprehensiveassessment was performed including outcome and assessment information set toinclude the presence of	2025-01-02

	revised as frequently as the patient's condition warrants due to a major decline or improvement in patient's health status in 1 of 2 active clinical records with home visits and wounds (Patients #2). Findings include: The clinical record of Patient #2 revealed an initial comprehensive assessment, dated 10/11/2024, authored by RN 2, included the primary diagnosis Stage 2 pressure ulcer (partial thickness open wound) wound of the right buttock, and a secondary diagnosis of Stage 2 pressure ulcer of the left buttock. The comprehensive assessment included documentation that a stage 2 left buttock pressure ulcer measured 3.4cm long x 3.5cm wide X .2 cm in depth and the stage 2 right buttock pressure ulcer measured 3 cm long x 4.5 cm wide x .2 cm deep. Documentation included 1) a skin tear to the left forearm measuring 7 cm long x 2 cm wide X .2 cm deep and 2) a skin tear to the left lower leg measuring 6.5 cm long X 3.8 cm wide X .2 cm deep. Documentation from skilled nurse visit notes dated 11/04/2024, 11/08/2024,		accurate wound measurements. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur. The agency will conduct a mandatory Inservice training on1/2/25 for all clinical staff focusing on the need to perform comprehensiveassessments as frequently as the patient's condition warrants due to a majordecline or improvement in patients health status to include when to perform initialwound measurements. All clinical staffwere reeducated on reporting any declines or improvements in patients' healthstatus to the Clinical Manager in real time so that a updated comprehensiveassessment can be completed at this time including physician notification. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. Clinicalmanager or designee	

	11/11/2024, 11/14/2024, and 11/19/2024 measure the right buttock wound as 0 cm X 0 cm X 0 cm, indicating a healed wound. The clinical record failed to evidence a comprehensive reassessment to reflect the change in Patient's condition. On 12/04/2024, SN visit note documentation revealed a newly opened wound, a stage 2 right buttock ulcer, that was treated, and a new skin tear was documented to the right lower leg skin tear that was treated. The RN failed to evidence measurements of the new wounds to the right buttock and right lower leg. The clinical record failed to evidence a comprehensive reassessment to reflect the new wounds to right buttock and right lower leg. During an interview on 12/05/2024 beginning at 3:30 PM, Clinical Manager relayed comprehensive assessment includes Outcome and Assessment information set (OASIS) information and the agency does not revise the comprehensive assessment except for every 60 days. During an interview on			

	PM, RN 2 relayed the right lower leg skin tear was new and the reopening of the right buttock was new at the 12/04/2024 visit. RN revealed the two new wounds were not measured and should have been. 410 IAC 17-14-1(a)(1)(B)			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan.	G0572	1. How the deficiency will be or has beenimmediately corrected. As itrelates to cited observation relating to Patient #6 , the agency is committed tocompleting and updated comprehensive assessment to include measurable paingoals and interventions. This assessmentwill be completed upon patient #6 return to caseload and will be reviewed andapproved by Clinical manager. Ongoing education including proper OASISdocumentation, focusing on accuracy, completeness, and the importance of theassessment in care planning with emphasis on pain assessment with measurablegoals relating to pain management will be provided to all clinical staff	2025-01-02

	Based on record review and interview, the agency failed to ensure each patient received the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals for 1 of 1 active records reviewed for a recertified patient. (Patient 6) The Findings Include: The clinical record for Patient 6 included a recertification comprehensive assessment dated 11/29/24 which identified pain that interfered with activity. The plan of care for the recertification 12/03/2024 – 01/31/2024 failed to include interventions or measurable goals related to pain. During an interview on 12/6/24 beginning at 11:50 AM, the CS indicated the POC was not complete, there were no goals or interventions for pain.		noless than quarterly as of 01/02/2025. The Quality Assuranceteam will review 100% of all submitted OASIS documentation for accuracy andcompleteness. If an OASIS assessment appears incomplete or inconsistent withother available assessment data, the QA team will confer with the assessingclinician and request revisions as appropriate. This 100% auditing will beongoing. If the quality assurance review team identifies trends in a specificclinician's assessment documentation, the quality assurance review team willprovide additional one-on-one education to that clinician. 2. How thedeficiency will be prevented from recurring i.e. measure put into place orsystematic changes made to ensure the deficiency will not recur. Ongoingeducation including proper OASIS documentation, focusing on accuracy,completeness, and the importance of the assessment in care planning withemphasis	

			development of measurable goals will beprovided to all clinical staff no less than quarterly as of 01/02/2025. As part ofour QAPI program the quality assurance team will review 100% of all submittedOASIS documentation and associated plan of cares for patient-specific,measurable outcomes and goals that address the patient's need for skilledservices, disease processes and symptoms. If the quality assurance teamidentifies a plan of care that includes broad or generic goals and/or fails toaddress patient-specific disease processes and/or symptoms, the QA team willconfer with the assessing clinician and request revisions and/or collaborationwith the MD as appropriate. This 100% auditing will be ongoing. If the qualityassurance review team identifies trends in a specific clinician's establishedgoals and outcomes, the quality assurance review team will provide additional one-on-oneeducation to that clinician.	

			3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. ClinicalManager or designee	
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 the deficiency will be or has beenimmediately corrected. As itrelates to patient #1, The agency has amended the Plan of Care to reflectPatient #1's residence at Entity F. Patient #1's physician has also beennotified in this process. As itrelates to patient #2, the Occupational Therapy Plan of Care has beenincorporated into the patient's medical Plan of Care. Patient # 2's Plan ofCare has also been updated to include bleeding precautions as a safety need.Home Health Aide services were discontinued per family request on 10/22/24 andis reflected as such in current POC. Patients #1's physician has also beennotified of each if these occurrences. As itrelates to patient #3, the patients POC was updated to include additionaldiagnosis and	2025-01-02

	education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview the agency failed to ensure the individualized plan of care included the types of services, supplies, equipment required, nutritional requirements, medications and treatments, and or safety measures to protect against injury for 6 of 7 active records reviewed. (Patient 1, 2, 3, 4, 5, and 7) The Findings Include: 5.The record reviewed on 12/5/24 for Patient 7 included a comprehensive assessment dated 11/12/24 indicated the patient was on hemodialysis three times per week. The plan of care failed to evidence safety measures for fistula care nor dietary restrictions for a dialysis patient. During an interview on 12/5/24 beginning at 1:30 PM, staff nurse at Other Entity G indicated Patient 7 had a 36-ounce daily fluid restriction and received hemodialysis every		need for admission to home health services as reflected in thesurvey citation. Patient #3's physician has also been notified of these updatesto Plan of Care. As itrelated to patient #4, The patient's POC was updated to include the use andfrequency as INR test meter as part of the patient's DME. Additionally, thepatients POC was updated to include information regarding the ancillarycaregiver's role, services provided and the company providing the caregiverservices. Finally, the POC has been updated to include the urostomy supplies(under DME) and treatment orders. Patient #3's physician has also been notifiedin these updates to Plan of Care. As itrelated to patient # 5, Rivaroxaban, a generic alternative to Xarelto iscurrently reflected on the patients POC and Medication list. An ordercorrection updating bleeding precautions has been added under safety. Patient #5's physician has also been notifiedof these updates to Plan of Care.	

	Tuesday, Thursday and Saturday. During an interview on 12/6/24 beginning at 11:15 AM, the Clinical Supervisor indicated they would expect the plan of care to include safety measures for fistula care and any dietary restrictions. The Clinical Supervisor indicated they were not included on the plan of care for Patient 7. 'he clinical record of Patient #1 revealed an initial POC dated 11/23/2024 to 01/21/2025. The POC, signed by RN #1, included the ordered services for SN, PT, and OT; the POC did not include Entity F, the assisted living facility [ALF] where Patient #1 resides, nor did it specify the services provided by Entity F for Patient. During an interview on 12/04/2024 at 12:15 PM, the Clinical Manager stated that Patient #1 resided in Entity F, an ALF. She revealed that the initial POC for Patient #1 had not yet been reviewed and that she did not know if Entity F or the services they provided were listed in the POC. On 12/05/2024 at 3:30 PM, RN		As itrelates to Patient #7, safety measures relating to fistula care and Dietaryrestrictions (fluid restrictions) have been updated on POC. Patient #3'sphysician has also been notified of these updates to Plan of Care. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur. The agencywill conduct a mandatory in-service training on January 2nd , 2025 forall clinical staff on creating an individualized plan of care that captures allof the following: services, supplies, equipment required, nutritionalrequirements, medications and treatments, and safety measures to protectagainst injury.	

	1 confirmed that Patient #1 required assistance with activities of daily living and received health services from Entity F. 2. A review of Patient #2's clinical record revealed an initial POC dated 10/11/2024 to 12/9/2024. The POC included orders for the following services: SN once a week for one week, twice a week for four weeks, and once a week for one week, PT twice a week for four weeks, then once a week for four weeks, and OT with a frequency of "evaluate and treat." The medical POC did not specify OT frequency or individualized OT goals. An OT evaluation was completed on 10/18/24, and a separate OT POC dated 10/11/2024 to 12/9/2024 listed OT visit frequency as once a week for one week, then twice a week for six weeks starting on 10/18/24. The OT POC included Patient #2's OT goals. The POC also included a medication list that with Plavix (a blood thinner) for daily use; the POC failed to specify bleeding precautions as a safety		Additionally, specific education will be provided regardingincluding the following into all patients' plan of cares: safety measures suchas bleeding precautions for patients on blood thinners; listing all DME such asINR machines, ostomy supplies; documentation of the caregiver's role,availability and willingness; all skilled services to be performed. Agencyadministrator and Clinical manager met with the quality assurance reviewer on12/23/24 to discuss the survey findings and need for thorough review of allsubmitted plan of cares to ensure that the plan of cares are individualized tothe patient and capture all of the required elements.	

	need. An order for home health aide (HHA) services, signed by RN 2 on 10/11/24, ordered HHA twice a week for seven weeks starting the week of 10/20/2024; the medical POC failed to include HHA services or frequency. During an interview on 12/4/2024 at 12:25 PM, the Clinical Manager stated that Patient #2's POC did not include OT frequency, care, or goals, noting that OT had a separate POC. She also confirmed that bleeding precautions were not included as a safety measure on Patient #2's POC but should have been. 3. A review of Patient #3's clinical record revealed an initial POC dated 11/22/24 to 1/20/25. The POC included ordered services for skilled nursing (SN) once a week for two weeks, twice a week for two weeks, and once a week for five weeks. The POC identified the principal diagnosis as hypertension. However, a referral for home health services dated 11/19/24 and signed by the patient's primary care physician listed		Ongoingeducation including creating an individualized plan of care that captures allof the following: services, supplies, equipment required, nutritionalrequirements, medications and treatments, and safety measures to protectagainst injury will be provided to all clinical staff no less than quarterly asof 01/02/2025. The qualityassurance team will review 100% of all submitted plan of cares for accuracy andcompleteness. In the event a plan of care fails to encompass all of therequired elements or is not individualized to the patient, the QA team willconfer with the assessing clinician and request revisions as appropriate. If thequality assurance review team identifies negative trends in a specificclinician's plan of care development, the quality assurance review team willprovide additional one-on-one education to that clinician. The agencyis also committed to incorporating the accuracy of care planning into theAgency	

	additional diagnoses, including dyslipidemia, memory deficit, tinnitus, and pulmonary emphysema. The POC failed to document these diagnoses or the reason for admission to home health services. During an observation on 12/04/2024 at 9:47 AM, RN 1 revealed that the main reason for home health care for Patient #3 was memory issues. On 12/4/2024 at 12:02 PM, Patient #3's family member and caregiver, Other C, confirmed that the reason for home health care was short-term memory loss. On 12/5/2024 at 1:30 PM, the Clinical Manager stated that the POC for Patient #3 was still under review by quality assurance and had not been completed. 4. During a home visit on 12/4/2024 at 4:00 PM, Patient #4 was observed with a urostomy, a surgically created opening to allow urine to drain from the body. The urostomy had a collection bag attached to collect urine. A test meter for INR (international normalized		QAPI program for further compliance review. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. Clinical Manageror designee	

	patient's home. A review of Patient #4's clinical record revealed a POC dated 11/12/2024 to 1/10/2025. The POC listed Warfarin (a blood thinner) under the patient's medication list. However, the POC did not document the use of an INR test meter as part of the patient's durable medical equipment (DME) nor the frequency of INR testing. The POC also failed to include documentation of the caregiver's role, the services provided by the caregiver, or the company providing the caregiver services. Additionally, the POC did not include documentation of urostomy supplies under DME or supplies, nor did it contain treatment orders for urostomy care or stoma care. During an interview with Patient #4 on 12/4/2024 at 4:00 PM, the patient stated that RN #5 provided urostomy care, including changing the urostomy bag once a week. The patient also revealed that the INR test meter was used to conduct a blood test using a finger stick once a week and stated they were trained and			

	comfortable using the device. Additionally, the patient relayed that a caregiver provided personal care seven days a week. On 12/5/2024 at 1:30 PM, Other A, a family member and healthcare representative for Patient #4, confirmed that they were responsible for managing the patient's health care. Other A stated that Patient #4 was attempting to save money but had to pay out-of-pocket for personal care services provided seven days a week by the agency's sister company, Entity B. On 12/6/2024 at 12:00 PM, RN #5 stated that she provided urostomy care for Patient #4 twice a week at every visit. This care included cleansing the urostomy stoma with saline and attaching a new urostomy bag.			
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	G0580	1. How the deficiency will be or has beenimmediately corrected. As it relates to patients #1;2;3; and 4. The agency hasreceived signed plans of care from physician that covers dates of service fromStart of Care.	2025-01-02

	interview, the agency failed to ensure drugs, services, and treatments were administered only as ordered by a physician in 4 of 4 active clinical records reviewed with a home visits (Patients # 1, 2, 3, and 4). Findings include: 1.The agency policy titled "Coordination of Patient Services," revised 01/2019, indicated the patient's physician will be notified of missed visits via fax or clinician will contact the physician when there is a clinical impact on the patient. 2. The clinical record for Patient #1 included an initial POC for the certification period 11/23/2024 to 01/21/2025 with orders for 1) SN services once a week for one week then three times a week for 8 weeks with orders for wound care, 2) PT was ordered 2 times a week for 8 weeks, and 3) OT once a week for eight weeks. RN 3 provided care to Patient on 11/25/24 and 11/27/24 and a PT and OT evaluations were conducted on 11/27/2024. The clinical record failed to evidenced documentation of physician orders for the medical care provided. The POC failed to		2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur. The agency will conduct a mandatory in-service training forall clinical staff on obtaining and verbal orders from the patient's attending physicianprior to furnishing any additional services. Clinicians will be advised tocontact the Clinical Manager if they are unable to obtain a verbal order forthe administration of any drugs, services, and treatments. An initial in-servicedate is scheduled for January 2nd, 2025.	

	signature, and the clinical record failed to evidence a verbal order for the medical care provided beginning 11/23/2024 through 12/03/2024. During an interview on 12/04/2024 beginning at 12:15 PM, Clinical Manager relayed there was not an order for treatments. She revealed she wrote an order for Patient's care on 12/04/2024. 3. The clinical record for Patient #2 included an initial POC dated 10/11/2024 to 12/09/2024 with ordered services SN once a week for one week, twice a week for four weeks, then once a week for one week, PT twice a week for four weeks then once a week for four weeks, and OT frequency noted as evaluate and treat. An OT evaluation was completed 10/18/24. The record included a separate OT POC dated 10/11/24 to 12/9/14 with OT visit frequency of once a week for one week then twice a week for six weeks starting 10/18/24 and included Patient OT goals. The medical POC and the OT POC were signed by Patient's primary care physician on 11/14/24. The clinical record		The agency Clinical Manager will review each patientadmission to ensure that orders are received and written prior to thefurnishing of any services or the administration of any drugs or treatments.The agency Clinical Manager, Administrator and Quality Assurance reviewer willfollow agency policy regarding attainment of physician signature for allnecessary physician orders**.** Ongoing education including obtaining and writing physicianorders for all services, treatments and drugs prior to care will be provided toall clinical staff no less than quarterly as of 01/02/2025. The clinical manager will review 100% of admissions toensure that a physician's verbal order for care to include the administrationof any drugs, services and/or treatments has been obtained, written, and sentfor physician signature prior to care being furnished. Additionally, the agency will include this auditing in theirquarterly QAPI procedures. Each quarter, 10% of the	

	failed to evidence verbal orders for treatments and therapies provided beginning at the start of care on 10/11/24 to 11/14/24. During an interview on 12/04/2024 beginning at 12:25 PM, Clinical Manager relayed the clinical record did not include physician orders for services to include frequencies, treatments, nor therapies. 4. The clinical record for Patient #3 included an initial POC dated 11/22/2024 to 01/20/2025 with ordered services SN once a week for two weeks, twice a week for two weeks, and once a week for five weeks for assessments, education, and medication review. The initial start of care visit included a comprehensive assessment dated 11/22/2024 with subsequent SN visits on 11/27/24 and 12/04/2024. The clinical record included a verbal order, dated 11/22/2024, for SN visits once a week for two weeks, twice a week for two weeks, and once a week for five weeks. The plan of care failed to evidence a physician's signature. The clinical record failed to evidence a verbal order		agency's census is selectedat random for a quarterly chart audit. The quarterly chart audit form will nowinclude a section entitled "Care provided is covered by a physician order".This inclusion of this element will be included in quarterly QAPI. During thequarterly chart audits, if this element does not meet 100% accuracy, theclinical manager will meet with the clinician who treated the patient toprovide additional one-on-one education regarding obtaining and writingverbal orders prior to care. In the event of further noncompliance, the QAPI team willthen establish a plan of action and goal for increasing this element's accuracyto 100% prior to the next quarter's QAPI review. All QAPI findings arediscussed with the QAPI team quarterly. This element will be reviewedindividually during each quarterly QAPI meeting. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%.	

	for the specific nursing care provided from 11/22/2024 to 12/04/2024. During an interview on 12/04/2024 beginning at 10:40, Clinical Manager relayed there was no order for specific care provided to Patient. 5. During a home visit observation on 12/04/2024 at 4:00 PM, Patient #4 was observed with a urostomy, a surgically created opening to allow urine to drain from the body. The patient had a device attached to collect urine. The clinical record for Patient #4 revealed an initial plan of care dated 11/12/2024 to 01/10/2025 with the services ordered, SN twice a week for nine weeks, PT once a week for one week then twice a week for eight weeks, and OT once a week for four weeks. The clinical record evidenced RN 5 completed SN visits on 11/14/2024, 11/18/2024, 11/20/20/2024, 11/25/2024, 11/27/2024 and 12/02/2024; the visits included documentation of wound treatments provided to Patients		ClinicalManager or designee	

	urostomy care was provided during each visit. The clinical record failed to evidence the plan of care was signed by Patient's attending physician nor did the clinical record evidence orders for the home health services, treatments, and therapies provided by SN, PT, nor OT from the start of care to 12/05/2024. During an interview 12/04/2024 at 4:00 PM, Patient #4 stated that RN 5 provided urostomy care, including changing the urostomy bag once a week. In a separate interview on 12/6/2024 at 12:00 PM, RN 5 stated that she provided urostomy care twice a week for Patient #4 at every visit. This care included cleansing the urostomy stoma with saline and attaching a new urostomy bag. RN 5 relayed she had provided care to Patient; she had not yet submitted the POC to the physician to be signed and denied obtaining verbal nor written orders before the provision of care. 410 IAC 17-13-1(a)			

G0584	Verbal orders 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. Based on record review and interview the agency failed to ensure services were provided based on a physician or allowed practitioner's verbal orders, or verbal orders were authenticated and dated by the physician or allowed practitioner for 2 of 2 active records reviewed with use of anticoagulants or identified increased risk of bleeding. (Patient #5,6) The Findings Include:	G0584	1. How the deficiency will be or has beenimmediately corrected. As itrelates to patient #5, patient #5 currently has a signed plan of care coveringdates of service 11/19/24-1/17/25 and includes orders, goals and interventionsfor SN, PT, and OT services. As it relatesto patient #6, patient #6 currently has a signed plan of care covering dates ofservice 10/4/24-12/2/24 and includes orders, goals and interventions for OTservices. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur.	2025-01-02

	1. The record on 12/4/24 for Patient #5 included a POC for the recertification period 11/19/2024- 1/17/2025 indicated a SN visit frequency of 1 visit per week for 1 week, 2 visits per week for 2 weeks, 1 visit per week for 6 weeks, PT visit frequency of 1 visit per week for 1 week, 2 visits per week for 4 weeks, 1 visit per week for 4 weeks; and an OT visit frequency of 1 visit per week for 4 weeks. The record failed to evidence documentation verbal or written order was obtained for SN, PT or OT services as written on the POC. During an interview on 12/4/24 beginning at 2:40 PM, the Clinical Supervisor indicated there was no documentation that written or verbal orders were obtained. 2.The record on 12/5/24 for Patient 6 indicated OT visits were made on 11/08/2024,		The agencywill conduct a mandatory Inservice training for all clinical staff on creatingverbal orders on day of SOC to include frequency, interventions that will beincluded on POC to be sent to physician within 24-48 hours. Initial Inservice date is 1/2/25. Ongoingeducation to all clinical staff on the importance of creating verbal orders forcare at SOC no less than quarterly. Processes will be added each morning to monitor accuracy and complianceof SOC verbal orders for all disciplines. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. Clinicalmanager or designee	

	11/28/2024. The POC for the recertification period 10/4/24 – 12/2/24 failed to evidence an order for OT. During an interview on 12/6/24 beginning at 11:50 AM, the clinical supervisor indicated the OT wrote a clinical note for weekly visits, indicated there should have been a written order and be included on the POC, it was not.			
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation and interview, the agency failed to ensure written instructions outlining an treatments and therapy to be administered by agency personnel in 1 of 1 active clinical record reviewed with a home visit with physical therapy (Patient #4). Findings include: During a home visit observation on 12/04/2024 beginning at 4:00 PM, an agency folder was present with documentation of	G0618	1. How the deficiency will be or has beenimmediately corrected. Patient #4 was contacted by the Clinical Manager on 12/4/24to ensure the patient is aware of the treatment and therapy services ordered byhis physician and the frequency and duration of his visits. The clinical manager documented herconversation with the patient in the patient's chart. The patient verbalized understanding andrepeated the frequency instructions provided. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not	2025-01-02

	failed to evidence written documentation of therapies, treatments, nor services. The clinical record for Patient #4 included an initial POC dated 11/18/2024 to 01/10/2025 with the following services ordered: skilled nurse (SN) once a week for nine weeks, physical therapy (PT) once a week for one week then twice a week for eight weeks, and occupational therapy (OT) once a week for four weeks. During an interview on 12/04/2024 beginning at 4:00 PM, Patient #4 relayed the agency folder in the home contained all paperwork provided by the agency. Patient denied having received written documentation of treatments and therapies provided by agency. Patient denied knowing treatments and therapies to be expected from the agency.		recur. On 12/4/24 individualeducation was provided to the physical therapist providing physical therapy topatient #4 on completing a paper calendar for the patient with his frequencyand duration at start of care. The agency will conduct mandatory Inservice training on1/2/25 for all clinical staff including therapy services regarding providing awritten calendar with frequency and duration at all OASIS timepoints for allpatients. As part of the agency QAPI program the agency will perform asample audit via telephonic inquiry to 25% of patients and/or responsibleparties to ensure the presence of an accurate paper schedule is available tothe patient and/or responsible party at each OASIS timepoint. Findings from the audit will be reportedquarterly at the quarterly QAPI meeting. In the event of further noncompliancethe agency will initiate a performance	

			noncompliance. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. ClinicalManager or designee	
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, record review, and interview, the agency failed to ensure their staff followed accepted standards of practice for prevention of transmission of infections in 2 of 2 home visits of patients with wounds [RN 2 and RN3]. The findings include: 1. A policy with revised date of 5/27/2024 titled "Infectious Disease Control" indicated hands should be washed when moving from a contaminated body site to a clean body site,	G0682	1. How the deficiency will be or has beenimmediately corrected. As itrelates to patient #2, after surveyor identification RN #2 received immediate educationas to the importance of adhering to proper hand hygiene and glove changing. As itrelates to patient #3, after surveyor identification RN #3 received immediateeducation as to the importance of adhering to proper sanitation practicesincluding proper hand and equipment sanitation dry times; handwashing and glovechanging. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur. The agency will conduct a	2025-01-02

	after contact with blood, body fluids or contaminated surfaces. 2. During observation of care at the home of Patient #2 on 12/04/2024 beginning at 11:07 AM to 11:40 AM, RN 2 donned clean gloves, removed the soiled dressing from both wounds on the left forearm, then without hand hygiene and change of gloves, RN 2 applied the wound treatment and a clean dressing to each of the wounds. RN 2 donned [applied] clean gloves removed the soiled dressing from the wound on the left lower leg, then without hand hygiene and change of gloves, RN 2 applied the wound treatment and a clean dressing to the wound. RN 2 donned clean gloves removed the soiled dressing from the wound on the right lower leg, then without hand hygiene and change of gloves, RN 2 applied the wound treatment and a clean dressing to the wound. RN 2 rolled the Patient onto her right side and one open area to the left buttock and one open area to the right buttock were observed. RN2 donned clean gloves and applied ointment to both wounds without a change of gloves and hand hygiene. RN		mandatory in-service training on 1/2/25for all clinical staff on following all accepted standards of practice forprevention of transmission of infections. Additionally, during this inservice,agency clinicians will be presented with the contents of agency policy entitled"7-A Infection Disease Control". Education regarding proper hand hygiene andsanitation practices during wound care and dry time for sanitizing wipes willbe highlighted. Initial in-service date: January 2nd, 2025 Ongoing education regarding infection disease control toinclude proper hand hygiene and sanitation practices will be provided to allclinical staff no less than quarterly as of 01/02/2025. The clinical manager will include proper infection diseasecontrol education in all onboarding educational sessions. All agency clinicianswill be expected to demonstrate proper hand hygiene practices no less thanannually (as evidenced by signed competency forms in their HR file).	

	2 donned gloves and wiped equipment used for patient care (stethoscope, blood pressure cuff, and oxygen monitor) with a disposable sanitizing wipe and immediately place them into the nurse bag. Directions on the package of the disposable sanitizing wipe indicated a wet to dry time of two minutes. On 12/5/2024 beginning at 11:30 AM RN 2 indicated she did not use hand sanitizer after removing soiled bandage and before applying new dressing and before treating one wound before another. RN2 indicated that she was not aware of dry time for the disposable sanitizing wipes. 3. During an observation of care at the home of Patient #1 on 12/4/2024 from 2:36 PM to 3:15 PM, RN 3 donned clean gloves, removed the soiled dressing from the wound on the right heel, then without hand hygiene and change of gloves, RN 2 applied the wound treatment and a clean dressing to the wound. RN 3 donned clean gloves, removed the soiled dressing from the wound on the left buttock, then without hand hygiene and change of gloves,		3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. ClinicalManager or designee	

	RN 2 applied the wound treatment and a clean dressing to the wound. RN 3 donned gloves and wiped equipment used for patient care (stethoscope, blood pressure cuff, thermometer, oxygen monitor, and bandage scissors) with a disposable sanitizing wipe and immediately place them into the nurse bag. Directions on the package of the disposable sanitizing wipe indicated a wet to dry time of two minutes. On 12/4/2024 beginning at 3:07 PM RN 3 indicated she believed the dry time for the disposable sanitizing wipes to be one minute. Upon looking at disposable sanitizing wipe container label, RN 3 indicated the dry time was 2 minutes. On 12/5/2024 beginning at 3:39 PM, RN 3 indicated hand hygiene and changing gloves in between removal of old dressing and application of new dressing should be completed and indicated she did do it during the visit.			

G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview the agency failed to ensure their skilled professionals who provide services to patients prepared clinical notes for 4 of 4 [Patient # 1, 2, 4, and 5] active records reviewed with home visits and 1 of 1 [Patient #8] discharged record reviewed for hospitalization. The Findings Include: The clinical record for Patient 5 indicated OT visits were made on 11/27/24 and 11/29/24. The record failed to evidence documentation for the visits. During an interview on 12/4/24 beginning at 2:40 PM the Clinical Supervisor indicated there was no documentation for the 11/27/24 or 11/29/24 visits. # The agency policy titled "Documentation of Patient Services," revised 05/2023, indicated clinical notes including skilled nursing notes,	G0716	1. How the deficiency will be or has beenimmediately corrected. As it relates to patient #5. OT visits for 11/27 and 11/29 werecompleted and are present in the patient EMR. As it related to patient #1 SN visit notes dated 11/30 and12/2 were completed and are present in patient EMR. As it relates to patient #2 on 12/6/24 a comprehensiveassessment was performed identifying and reflecting wound care measurements forsited areas. As it relates to patient #4, PT note dated 12/2 wascompleted and is present in the patient's EMR. Further reviewing patient #4'schart we are unable to identify a COTA visit on 11/19. All other COTA visitsare completed and available in the patient's EMR. As it relates to patient #8, as the patient was transferredfrom our care on 7/27/24, the agency is unable to further address the citedobservation at this time.	2025-01-02

	visit notes, evaluations and assessments, physician orders, and communications were expected within 48 hours of visit date and times. # The clinical record for Patient #1 included an initial POC dated 11/23/2024 to 01/21/2025 with ordered services as SN once a week for one week then three times a week for eight weeks, PT twice a week for 8 weeks, and OT once a week for eight weeks. On 12/03/24, the SN visit note for the 11/30/24 visit was undocumented. On 12/06/2024, the SN visit note for 12/02/2024 was not completed. During an interview on 12/04/2024 beginning at 12:15 PM, Administrator relayed the 11/30/2024 there was no SN visit made, the visit was missed, and the skilled nurse visit on 12/03/2024 was completed, yet not documented. # # The clinical record of Patient #2 revealed an initial comprehensive assessment completed on 10/11/2024 by RN 2 that included the primary diagnosis indicated stage 2 pressure ulcer (partial thickness open wound where skin wears		2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur. Agency Administrator and Clinical Manager met with thequality assurance reviewer on 12/23/24 to discuss the survey findings and needfor monitoring of all visit notes that are not documented in a timely fashionas well as thorough review of all notes for completeness and accuracy. As animprovement to our current practice. the Clinical manager will run a weeklyreport of any visits that are not yet documented and are 2 business days orolder. The clinical manager will contact each clinician who has outstandingnotes and request that the notes be submitted within 24 hours. The Clinical Managerwill continue following up with the assessing clinician daily until these notesare resolved. The agency will conduct mandatory in-service training forall clinical staff on	

	away) wound of the right buttock, and a secondary diagnosis included stage 2 pressure ulcer of the left buttock. The wound care documentation of the comprehensive assessment included a stage 2 left buttock pressure ulcer that measured 3.4cm long X 3.5cm wide X .2 cm in depth, a stage 2 right buttock pressure ulcer that measured 3 cm long X 4.5 cm wide X .2 cm deep, a skin tear to the left forearm measuring 7 cm long X 2 cm wide X .2 cm deep, and a skin tear to the left lower leg measuring 6.5 cm long X 3.8 cm wide X .2 cm deep. Right buttock wound was measured at 0 cm X 0 cm X 0 cm for SN visits on 11/4/24, 11/08/2024, 11/11/2024, 11/14/2024, and 11/19/2024. On 12/04/2024, SN visit note documentation revealed a stage 2 right buttock ulcer that was treated and not measured, only noted as pea sized. A new skin tear was documented to the right lower leg skin tear that was treated and not measured. The clinical record failed to evidence measurements of newly opened right buttock pressure ulcer nor the new right lower leg skin tear.		and timely documentation ofclinical notes. During this training, agency policy entitled"Documentation of Patient Services" will be reviewed with all clinicalstaff. Additionally, agency clinicians will be educated on the importance ofcomprehensive documentation as it relates to new or worsening symptoms (i.e.new wounds) and that if their assessment reveals as such, the assessingclinician must contact the agency supervisor and the patient's MD. Initialin-service date is scheduled for January 2nd, 2025 Ongoing education regarding appropriate, comprehensive andtimely documentation of clinical notes will be provided to all clinical staffno less than quarterly as of 01/02/2025 as well as during all onboardingprocedures. The quality assurance review team will review 100% of allsubmitted visit notes for timeliness, comprehensiveness and accuracy. If thequality assurance team notes a change to the patient's condition during review,the clinical manager will be notified, and the note will be returned to theclinician requesting	

G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the agency failed to ensure the RN provided the home health aide (HHA) patient specific instructions and precautions in 1 of 1 active clinical record with home health aide (HHA) service and a home visit (Patient #2). Findings include: The clinical record for Patient #2 included an initial POC dated 10/11/2024 to 12/09/2024 with ordered services SN, PT, and OT and a diet ordered as diabetic pureed (whipped or mashed consistency). The medication list on the medical POC included a daily dose of Plavix, a blood thinner that prevents clots. The clinical record included an order dated 10/13/2024 for HHA services to begin the week of 10/20/2024 twice a week for	G0798	1. How the deficiency will be or has beenimmediately corrected. As itrelates to patient number 2, agency revised the home health aide care plan toinclude evidence of a pureed diet and anticoagulant precautions. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur. The agencywill conduct a mandatory Inservice training for all clinical staff focusing onaccuracy of Home Health Aide care plan to include diet, safety precautions,added allergies, functional limitations, and activities permitted. Initial Inservice date is scheduled for1/2/25. Ongoingeducation including importance of accurate Home Health Aide care plandocumentation to include diet, safety precautions, added allergies, functionallimitations, and activities permitted will be provided to clinical staff noless than quarterly. As part ofthe agencies QAPI	2025-01-02

	dated 10/11/2024 to 12/09/2024, signed by RN 2, indicated Patient's diet is diabetic. The HHA POC failed to evidence a pureed diet and anticoagulant precautions. During an interview on 12/04/2024 beginning at 12:25 PM, Clinical Manager relayed the pureed diet was not on the HHA POC nor are the bleeding precautions. 410 IAC 17-14-1(m)		program agency is committed to audit 100% of all Home Healthaide care plans for the accuracy. Findings will be reported at the quarterly QAPI meeting. In the event further noncompliance isidentified agency will initiate a performance improvement plan to addressnoncompliance. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. Clinical Manageror designee	
G0952	Ensure that HHA employs qualified personnel 484.105(b)(1)(iv) (iv) Ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies. Based on record review and interview, the agency administrator failed to ensure the agency employed qualified personnel in 1 of 1 agency. Findings include: The personnel record for home health aide (HHA) #1 failed to evidence an active HHA license. The review of the Indiana	G0952	1. How the deficiency will be or has beenimmediately corrected. On 12/3/24 Home Health Aide certification for Home Health Aide#1 was identified by Administrator as being expired. Administrator immediately notified ClinicalManager and Home Health Aide #1. HomeHealth Aide #1's patients were immediately reassigned to a qualified Home HealthAide. Home Health Aide #1 wasre-instated on 12/5/24 by the State of Indiana. 2. How the deficiency will be	2025-01-02

	Professional Licensing Agency revealed HHA #1 certification expired in August of 2023. During an interview on 12/05/2024 beginning at 2:00 PM, Administrator relayed she identified the certification was expired on 12/03/2024 and rescheduled her patients with another HHA. 410 IAC 17-12-1(d)(3)		measure put into place or systematic changes made to ensure thedeficiency will not recur. Personnelfiles will now be reviewed monthly by the Administrator or designee. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. Administratoror designee	
G0984	In accordance with current clinical practice 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Based on record review and interview, the agency failed to ensure the agency adopted and provided services in accordance with current clinical practice guidelines and standards of practice in 1 of 1 active clinical record with a home visit with new wounds assessed (Patient #2). Findings include:	G0984	1. How the deficiency will be or has beenimmediately corrected. As it relates to patient #2 on 12/6/24 a comprehensiveassessment was performed identifying and reflecting wound care measurements forsited areas. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur. The agency will conduct mandatory Inservice training for allclinical staff on current clinical practice guidelines and	2025-01-02

	The clinical record of Patient #2 revealed a skilled nurse note dated 12/04/2024 with documentation of two new wounds, a pea sized opening noted in a previously healed right buttock area on 11/05/2024, and a new skin tear was noted to the right lower extremity. The right buttock and right lower leg wounds were treated but the record failed to evidence wound measurements. During an interview on 12/03/2024 beginning at 2:30 PM, Clinical Manager relayed there was not wound care policy, the clinicians were instructed to measure wounds weekly. During an interview on 12/05/2024 beginning at 12:38 PM, Registered nurse (RN) 2 relayed the right lower leg skin tear was new and the reopening of the right buttock was new at the 12/04/2024 visit. RN revealed the two new wounds were not measured and should have.		standards ofpractice as it relates to the identification, assessment and measurement of allnew and unresolved wounds. InitialInservice date is scheduled for **1**/2/25. Ongoing education including current clinical practiceguidelines and standards of practice will be provided to all clinical staff noless than quarterly as of 1/2/25. Clinical manager or designee will review 100 % of allclinical notes for any new wound assessments and documentations to ensure inclusionof wound measurements. If the Clinicalmanager or designee identifies trends in a specific clinical wound assessmentthe clinical manager will provide additional one on one education to thatclinician. Findings from 100% clinicalreview will be reported to QAPI team for further consideration and need foradditional audit activities and correction action. 3. Who is responsible to ensure the deficiencywill be/has been	

			corrected and compliance maintained at 100%. Clinical Manageror designee	

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
Michelle Yablonowski	Administrator	1/3/2025 12:32:40 PM