| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15K118 | A. BUILDING<br>B. WING | 02/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HOMETOWN HOME HEALTHCARE INC | 302 E NORTH B STREET, GAS CITY, IN, 46933 |

| (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 |
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| G0000 | INITIAL COMMENTS<br><br>This visit was for a Federal/State complaint survey of a Home Health Provider.<br><br>Survey Dates: February 3, 4, 5 and 6, 2025<br><br>Complaint: IN112454 with related deficiencies cited.<br><br>12 Month Unduplicated Skilled Admissions: 13<br><br><u>Abbreviations</u><br>CM-Clinical Manager, HHA-Home Health Aide, RN-Registered Nurse, POC-Plan of Care, ROC-Resumption of Care, SOC-Start of Care<br><br>QR A2 2/17/25 | G0000 | | |
| G0572 | Plan of care<br><br>484.60(a)(1) | G0572 | G0572 Director of Clinical Services will ensure that the client will receive services as ordered in the POC. Director of Clinical Services or scheduler will notify MD on any services missed weekly. Scheduler will notify client if | 2025-02-28 |

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| | 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.<br><br>Based on record review and interview, the home health agency failed to ensure the patient received all HHA services as ordered in the plan of care for 4 of 5 records reviewed (Patient #2, 3, 4 and 5).<br><br>Findings include:<br><br>1. The undated agency policy "Home Care Bill of Rights" indicated the patient has the right to receive all services outlined in the plan of care.<br><br>2. The undated agency policy "Plan of Care" indicated the client and other agency personnel shall participate in developing the Plan of Care and the client shall be informed of any changes in the Plan of Care.<br><br>3. Patient #2's clinical record | | services are unable to be provided and will be rescheduled when possible. Director of Clinical Services to educate scheduler to place notes in client chart to document missed services, when client contacted, and if services are able to be rescheduled. Director of Clinical Services to monitor charts monthly to ensure that missed visits are documented and MD notified. | |

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| | evidenced a POC for the certification period 12/27/24 to 2/24/25. The POC included orders for HHA visits two hours a day, five days a week. The record failed to evidence HHA visits were completed five days a week for the weeks of 12/22/24 and 12/29/24.<br><br>During an interview on 2/5/25 at 1:05 PM, Patient #2 relayed the home health agency doesn't notify him when they are not making a visit and he is unable to bathe that day by himself.<br><br>During an interview on 2/6/25 at 9:55 AM, the CM confirmed that Patient #2 did not receive HHA visits as ordered in the POC.<br><br>4. Patient #3's clinical record evidenced a POC for the certification period 1/04/25 to 3/04/25. The POC included orders for HHA visits two hours a day, three days a week. The record failed to evidence HHA visits were completed three days a week for the weeks of 12/15/24, 12/22/24, 12/29/24, 1/05/25, 1/12/25, 1/19/25 and 1/26/25.<br><br>During an interview on 2/05/25 | | | |

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| | she requested HHA visits on Mondays, Wednesday and Friday since SOC and she never knew when the HHA's were scheduled. She had several days when no one showed up and the agency didn't call to give her notice that the HHA would not be making a visit. She also relayed the agency sent several different HHA's and she requested one set HHA.<br><br>During an interview on 2/06/25 at 10:05 AM, the CM confirmed that Patient #3 notified the agency when she went out of town and the clinical record failed to evidence documentation of this. She also relayed the home health agency failed to notify the physician regarding the change in HHA visit frequencies and she confirmed that Patient #3 did not receive HHA visits as ordered in the POC.<br><br>5. Patient #4's clinical record evidenced a POC for the certification period 1/07/25 to 3/07/25. The POC included orders for HHA visits two hours a day, three days a week. The record failed to evidence HHA visits were completed three days a week for the weeks of | | | |

12/08/24, 12/15/24, 12/22/24, 12/29/24, 1/12/25 and 1/19/25 and failed to evidence documentation of attempting to reschedule the missed visits.

During an interview on 2/06/25 at 10:13 AM, the CM confirmed Patient #4 did not receive HHA visits as ordered in the POC and she confirmed the clinical record did not include documentation of attempts to reschedule any HHA visits.

6. Patient #5's clinical record evidenced a POC for the certification period 1/16/25 to 3/16/25. The POC included orders for HHA visits two hours a day, five days a week. The record failed to evidence HHA visits were completed five days a week for the weeks of 12/22/24 and 1/05/25 and failed to evidence documentation of attempting to reschedule the missed visits.

During an interview on 2/06/25 at 10:20 AM, the CM confirmed Patient #5 did not receive HHA visits as ordered in the POC and she confirmed the clinical record did not include documentation of attempts to reschedule any HHA visits.

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| | 410 IAC 17-13-1(a) | | | |
| G0574 | Plan of care must include the following<br><br>484.60(a)(2)(i-xvi)<br><br>The individualized plan of care must include the following:<br>(i) All pertinent diagnoses;<br>(ii) The patient's mental, psychosocial, and cognitive status;<br>(iii) The types of services, supplies, and equipment required;<br>(iv) The frequency and duration of visits to be made;<br>(v) Prognosis;<br>(vi) Rehabilitation potential;<br>(vii) Functional limitations;<br>(viii) Activities permitted;<br>(ix) Nutritional requirements;<br>(x) All medications and treatments;<br>(xi) Safety measures to protect against injury;<br>(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.<br>(xiii) Patient and caregiver education and training to facilitate timely discharge;<br>(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;<br>(xv) Information related to any advanced directives; and<br>(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.<br><br>Based on observation, record | G0574 | G0574 Administrator educated Director of Clinical Services to conduct a medication review or reconciliation of all medications (prescription and nonprescription) with all SOC, ROC, and recertification assessments and each time a client reports a new medication. Director of Clinical Services to notify PCP of any new orders or discrepancies noted, receive a verbal order, including datetime/and person information verified with, then send the order to PCP for signature. Director of Clinical Services audited all charts to ensure there is an initialized care plan for each patient. All active clinical charts will be audited quarterly and will continue to be audited until closed. | 2025-02-28 |

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| | review, and interview, the home health agency failed to ensure the POC included accurate medications the patient is taking for 3 of 4 active records reviewed with SOC in the past 6 months (Patient #1, 2 and 3).<br><br>Findings include:<br><br>1. The undated agency policy "Comprehensive Client Assessment" indicated the comprehensive assessment will include a review of all medications the client is using (prescription and nonprescription).<br><br>2. The undated agency policy "Plan of Care" indicated the Plan of Care shall be completed in full to include all medications, treatments and procedures.<br><br>3. Patient #1's clinical record evidenced a SOC on 7/24/24 and included a POC and medication profile for the certification period 1/20/25 to 3/20/25. The clinical record failed to evidence the Registered Nurse (RN) Case Manager conducted a medication review or reconciliation of Patient #1's medications. | | | |

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| | During a home visit observation conducted with Patient #1 and HHA 1 on 2/03/25 at 3:00 PM, Surveyor comparison of the home health agency's POC medication list against the medications in the home evidenced the following discrepancies:<br><br>-Baclofen (used to treat back pain) 10 milligram (mg), 1 tablet every 8 hours as needed was listed on the POC. This medication was not found in the home.<br><br>-Loratadine (used to treat allergies) 10 mg, 1 tablet daily was listed on the POC. This medication was not found in the home.<br><br>During an interview on 2/03/25 at 3:40 PM, Patient #1 relayed she did not have the Baclofen or Loratadine medications in the home and she had not been taking the medications for several months.<br><br>4. Patient #2's clinical record evidenced a SOC on 8/29/24, a ROC on 12/30/24 and included a POC and medication profile for the certification period 12/27/24 to 2/24/25. The | | | |

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| | the Registered Nurse (RN) Case Manager conducted a medication review or reconciliation of Patient #2's medications during the ROC visit on 12/30/24.<br><br>During a home visit observation conducted with Patient #2 and HHA 2 on 2/04/25 at 1:05 PM, Surveyor comparison of the home health agency's POC medication list against the medications in the home evidenced the following discrepancies:<br><br>-Torsemide (used to treat heart failure) 10 mg, 2 tablets on Monday, Wednesday and Friday was found in the home. This medication was listed on the POC as 1 tablet twice a day on M-W-F.<br><br>-Lantus Solustar Pen 100 units/ml (used to treat diabetes) was found in the home. This medication was listed on the POC as 15 units daily. Patient #2 stated he is taking 15 units twice a day.<br><br>-Breo-Ellipta (used to treat asthma) 100/25 microgram (mcg) Inhaler was found in the home. The POC failed to | | | |

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| | Patient #2 stated he is taking this inhaled once a day.<br><br>-Albuterol Sulfate (used to treat asthma) 90 mcg inhaler was found in the home. The POC failed to evidence this medication listed. Patient #2 stated he used this inhaler as needed.<br><br>During an interview on 2/04/25 at 1:15 PM, Patient #2 relayed the Lantus was prescribed on 12/27/24 and he has been using the Breo-Ellipta and Albuterol Sulfate inhalers for a year.<br><br>5. Patient #3's clinical record evidenced a SOC on 9/27/24 and included a POC and medication profile for the certification period 1/04/25 to 3/04/25. The clinical record failed to evidence the Registered Nurse (RN) Case Manager conducted a medication review or reconciliation of Patient #3's medications during the comprehensive assessment visit on 1/03/25.<br><br>Review of the medication list on the POC for Patient #3 failed to evidence a muscle relaxer listed.<br><br>During an interview on 2/05/25 | | | |

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| | at 3:56 PM, Patient #3 relayed she was prescribed Cyclobenzaprine (a muscle relaxer) from the pain clinic and she had been taking this medication for a long time for chronic back and neck pain.<br><br>During an interview on 2/06/25 at 10:25 AM, the CM confirmed the POC for Patient #3 did not include a muscle relaxer.<br><br>410 IAC 17-13-1(a)(1)(C)(ix) | | | |
| G0576 | All orders recorded in plan of care<br><br>484.60(a)(3)<br><br>All patient care orders, including verbal orders, must be recorded in the plan of care.<br><br>Based on record review and interview, the home health agency failed to document ROC orders were received from the attending practitioner for 1 of 1 active record reviewed with a ROC (Patient #2).<br><br>Findings include:<br><br>1. The undated agency policy "Physician Orders" indicated all medications and treatments, that are part of the client's plan of care, must be ordered by a | G0576 | G0576 Administrator educated Director of Clinical Services to obtain and document verbal orders received for ROC assessments and medication reconciliation. Director of Clinical Services to notify PCP of any new orders or discrepancies noted, documentation to include date/time/and person information verified with, along with order sent to PCP for signature. All active client charts have been audited to ensure all orders are recorded in the plan of care for each patient. All active client charts will be audited quarterly, audits will continue indefinitely until chart is closed. | 2025-02-28 |

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| | physician, all verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders and the order must include the date, specific order, be signed with full name and title of person receiving the order and be sent to the physician for signature.<br><br>2. The undated agency policy "Comprehensive Client Assessment" indicated the resumption of care assessment identifies changes in diagnosis and/or service needs and a verbal order to resume care and for any changes in the plan of care will be sent to the physician.<br><br>3. The undated agency policy "Patient Reassessment/Update of Comprehensive Assessment" indicated physician orders will be completed for all reassessment visits and/or verbal orders for changes to the (485) plan of care.<br><br>4. Patient #3's clinical record evidenced a hospital hold from 12/26/24 to 12/29/24, a ROC assessment completed on 12/30/24 and included a POC | | | |

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| | for the certification period 12/27/24 to 2/24/25. The record failed to evidence documentation of collaboration with the attending practitioner for the ROC.<br><br>5. During an interview on 2/06/25 at 9:55 AM, the CM relayed she did not collaborate with the attending practitioner for ROC orders. | | | |
| G0580 | Only as ordered by a physician<br><br>484.60(b)(1)<br><br>Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner.<br><br>Based on record review and interview, the home health agency failed to ensure services were provided only as ordered by a physician or allowed practitioner for 3 of 4 patient records reviewed who were admitted within the past 6 months (Patient #2, 3 and 4).<br><br>Findings include:<br><br>1. The undated agency policy "Physician Orders" indicated all medications and treatments, | G0580 | G0580 Director of Clinical Services to ensure drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Director of Clinical Services to educate staff to follow HHA care plans and to not provide any services not ordered. Director of Clinical Services to educate scheduler to update client with any services changes, document notification, and attempts to reschedule services in client chart. Administrator educated Director of Clinical Services to obtain and document all verbal orders with date/time/and person information verified with, then send to PCP for signature. Director of Clinical Services audited all active client charts to ensure client is receiving all ordered services. RN to review HHA care plan with each supervisory visit and assessment. | 2025-02-28 |

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| | of care, must be ordered by a physician, all verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders and the order must include the date, specific order, be signed with full name and title of person receiving the order and be sent to the physician for signature.<br><br>2. Patient #2's clinical record included a POC for the certification period 12/27/24 to 2/24/25 with orders for HHA visit frequencies of two hours a day, five days a week. The record evidenced HHA visits were performed on 12/30/24, 1/01/25, 1/02/25, 1/03/25, 1/06/25, 1/07/25, 1/08/25, 1/09/25, 1/10/25, 1/13/25 and 1/14/25. The clinical record for Patient #2 failed to include a verbal or signed written order for the SN frequencies was obtained prior to the above visits performed.<br><br>During an interview on 2/06/25 at 9:55 AM, the CM relayed she did not obtain a verbal order from the attending practitioner for the recertification POC. | | | |

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| | 3. Patient #3's clinical record included a POC for the certification period 1/04/25 to 3/04/25 with orders for HHA visit frequencies of two hours a day, three days a week. The record evidenced HHA visits were performed on 1/08/25, 1/10/25, 1/14/25, 1/16/25, 1/23/25, 1/28/25, 1/30/25 and 2/04/25. The clinical record for Patient #3 failed to include a verbal or signed written order for the SN frequencies was obtained prior to the above visits performed.<br><br>During an interview on 2/06/25 at 10:05 AM, the CM relayed she did not obtain a verbal order from the attending practitioner for the recertification POC.<br><br>4. Patient #4's clinical record included a POC for the certification period 1/07/25 to 3/07/25 with orders for HHA visit frequencies of two hours a day, three days a week. The record evidenced HHA visits were performed on 1/08/25 and 1/10/25. The clinical record for Patient #3 failed to include a verbal or signed written order for the SN frequencies was obtained prior to the above | | | |

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| | visits performed.<br><br>During an interview on 2/06/25 at 10:13 AM, the CM relayed she did not obtain a verbal order from the attending practitioner for the recertification POC.<br><br>410 IAC 17-13-1(a) | | | |
| G0588 | Reviewed, revised by physician every 60 days<br><br>484.60(c)(1)<br><br>The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date.<br><br>Based on record review and interview, the home health agency failed to review the POC with the attending practitioner during the ROC for 1 of 1 active record reviewed with a ROC (Patient #2).<br><br>Findings include:<br><br>1. The undated agency policy "Physician Orders" indicated all medications and treatments, that are part of the client's plan of care, must be ordered by a physician, all verbal orders must | G0588 | G0588 Administrator educated Director of Clinical Services to complete an individualized plan of care that is reviewed, revised by the physician every 56-60days beginning with the start of care date. All assessments to have a date and time in/out stated on assessment. All verbal orders are to have date/time/and person information verified with documented and then sent to PCP for signature. All active client charts have been audited. Active client charts will be audited quarterly to ensure all information is documented. Audits will continue until chart is closed. | 2025-02-28 |

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| | be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders and the order must include the date, specific order, be signed with full name and title of person receiving the order and be sent to the physician for signature.<br><br>2. The undated agency policy "Comprehensive Client Assessment" indicated the resumption of care assessment identifies changes in diagnosis and/or service needs and a verbal order to resume care and for any changes in the plan of care will be sent to the physician.<br><br>3. The undated agency policy "Patient Reassessment/Update of Comprehensive Assessment" indicated physician orders will be completed for all reassessment visits and/or verbal orders for changes to the (485) plan of care.<br><br>4. Patient #3's clinical record included a SOC on 8/29/24 and evidenced a hospital hold from 12/26/24 to 12/29/24. A ROC assessment was completed on 12/30/24. The record failed to | | | |

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| | evidence documentation of collaboration with the attending practitioner for the ROC POC.<br><br>5. During an interview on 2/06/25 at 9:55 AM, the CM relayed she did not collaborate with the attending practitioner regarding the ROC POC.<br><br>410 IAC 17-13-1(a)(2) | | | |
| G0590 | Promptly alert relevant physician of changes<br><br>484.60(c)(1)<br><br>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.<br><br>Based on record review and interview, the home health agency failed to ensure the physician or allowed practitioner was promptly notified of the need to alter the POC related to missed visits for 4 of 5 patient records reviewed (Patient #2, 3, 4 and 5).<br><br>Findings include:<br><br>1. The undated agency policy "Home Care Bill of Rights" indicated the patient has the right to receive all services | G0590 | G0590 Administrator educated Director of Clinical Services and scheduler to notify MD of any changes to client's POC, including missed visits. MD to be notified of any missed visits weekly. Missed visits will be documented in client chart, along with client notification and attempt to reschedule missed visits. Director of Clinical Services to monitor client charts/schedules monthly to ensure missed visits are documented. All active client charts were audited by the Director of Clinical Services to ensure accuracy. All active client charts will be audited quarterly until client chart is closed. | 2025-02-28 |

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| | outlined in the plan of care.<br><br>2. The undated agency policy "Plan of Care" indicated professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care.<br><br>3. Patient #2's clinical record evidenced a POC for the certification period 12/27/24 to 2/24/25. The POC included orders for HHA visits two hours a day, five days a week. The record failed to evidence HHA visits were completed five days a week for the weeks of 12/22/24 and 12/29/24 and failed to include documentation of collaboration with the attending practitioner regarding the need to alter the POC frequencies.<br><br>During an interview on 2/6/25 at 9:55 AM, the CM confirmed that Patient #2 did not receive HHA visits as ordered in the POC and she confirmed the clinical record failed to evidence documentation of collaboration with the attending practitioner regarding the need to alter the POC frequencies.<br><br>4. Patient #3's clinical record | | | |

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| | certification period 1/04/25 to 3/04/25. The POC included orders for HHA visits two hours a day, three days a week. The record failed to evidence HHA visits were completed three days a week for the weeks of 12/15/24, 12/22/24, 12/29/24, 1/05/25, 1/12/25, 1/19/25 and 1/26/25 and failed to include documentation of collaboration with the attending physician regarding the need to alter the POC frequencies.<br><br>During an interview on 2/06/25 at 10:05 AM, the CM confirmed that Patient #3 did not receive HHA visits as ordered in the POC and the clinical record failed to evidence documentation of collaboration with the attending physician regarding the need to alter the POC frequencies.<br><br>5. Patient #4's clinical record evidenced a POC for the certification period 1/07/25 to 3/07/25. The POC included orders for HHA visits two hours a day, three days a week. The record failed to evidence HHA visits were completed three days a week for the weeks of 12/08/24, 12/15/24, 12/22/24, 12/29/24, 1/12/25 and 1/19/25 | | | |

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| | and failed to include documentation of collaboration with the attending physician regarding the need to alter the POC frequencies.<br><br>During an interview on 2/06/25 at 10:13 AM, the CM confirmed Patient #4 did not receive HHA visits as ordered in the POC and she confirmed the clinical record did not include documentation of collaboration with the attending physician regarding the need to alter the POC frequencies.<br><br>6. Patient #5's clinical record evidenced a POC for the certification period 1/16/25 to 3/16/25. The POC included orders for HHA visits two hours a day, five days a week. The record failed to evidence HHA visits were completed five days a week for the weeks of 12/22/24 and 1/05/25 and failed to include documentation of collaboration with the attending physician regarding the need to alter the POC frequencies.<br><br>During an interview on 2/06/25 at 10:20 AM, the CM confirmed Patient #5 did not receive HHA | | | |

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| | the clinical record did not include documentation of collaboration with the attending physician regarding the need to alter the POC frequencies.<br><br>410 IAC 17-13-1(a)(2) | | | |
| G0682 | Infection Prevention<br><br>484.70(a)<br><br>Standard: Infection Prevention.<br><br>The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.<br><br>Based on observation, record review and interview, the home health agency failed to ensure staff followed agency infection control policies and procedures related to hand hygiene for 1 of 1 home visit observation performed (HHA #1).<br><br>Findings include:<br><br>1. The undated agency policy "Handwashing/Hand Hygiene" indicated hand washing and hand antisepsis indications are to be done after removing gloves, before eating, drinking, handling food or serving food. | G0682 | G0682 Director of Clinical Services to educate staff on proper hand hygiene, hand washing, and hand antisepsis to be completed after removing gloves, before eating, drinking, handing food, or serving food. Director of Clinical Services to educate staff on wearing gloves for all patient care, while handling food, and serving food with hand hygiene performed prior to donning gloves and after doffing gloves. Director of Clinical Services and office staff to ensure staff completes hand hygiene inservice upon hire and yearly. RN to observe hand washing technique with every supervisory visit that staff is present. | 2025-02-28 |

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| | 2. During a home visit observation conducted with Patient #1 and HHA 1 on 2/03/25 at 3:00 PM, HHA 1 was observed assisting Patient #1 with a shower. After washing Patient #1's back, HHA 1 removed her gloves. HHA 1 failed to perform hand hygiene and failed to apply new gloves for the duration of the shower. Later during the visit, HHA 1 was observed preparing a meal for Patient #1. HHA 1 removed 2 frozen chicken fingers from a bag and placed them in the air fryer to cook. HHA 1 failed to wear gloves while touching the food.<br><br>3. During an interview on 2/04/25 at 3:03 PM, HHA 1 stated she was nervous during the home visit observation and she confirmed gloves should have been worn for the entire shower and when handling food. | | | |

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| | 4. During an interview on 2/04/25 at 3:10 PM, the CM relayed hand hygiene should have been performed when removing gloves and gloves should have been worn during the shower and when preparing food.<br><br>410 IAC 17-12-1(m) | | | |
| G1024 | Authentication<br><br>484.110(b)<br><br>Standard: Authentication.<br><br>All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.<br><br>Based on record review and interview, the home health agency failed to ensure all entries in the clinical record were appropriately authenticated, dated and timed for 4 of 5 patient records reviewed (Patient #2, 3, 4 and 5).<br><br>Findings include:<br><br>1. The undated agency policy | G1024 | G1024 Administrator to educate Director of Clinical Services to properly date, time in and out, and sign legibly all SOC, ROC, and recertification assessments. Director of Clinical Services to audit client charts quarterly to ensure proper documentation has been completed. All active client charts have been audited by Director of Clinical Services. All active client charts will be audited quarterly until client chart is closed. | 2025-02-28 |

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| | indicated a separate note shall be completed for each visit and signed and dated by the appropriate professional and the actual time of the patient visit will be included in each note<br><br>2. Patient #2's clinical record evidenced a ROC comprehensive assessment performed on 12/30/24 by the CM. The comprehensive assessment visit note failed to evidence a time in and time out and failed to evidence the date and time the patient and the nurse signed the comprehensive assessment.<br><br>During an interview on 2/06/25 at 9:55 AM, the CM relayed the comprehensive assessment was completed on 12/30/24 and confirmed the comprehensive assessment visit note failed to include visit times and failed to include signatures of the patient and nurse on the visit note.<br><br>3. Patient #3's clinical record evidenced a comprehensive assessment performed on 1/03/25 by the CM. The comprehensive assessment visit note failed to evidence a time in and time out; failed to evidence | | | |

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| | the date and time the patient signed the visit note and failed to evidence the time the CM signed the visit note.<br><br>During an interview on 2/06/25 at 10:05 AM, the CM relayed the comprehensive assessment was completed on 1/03/25 and confirmed the comprehensive assessment visit note failed to include a time in and out and failed to include a time when the patient and nurse signed the visit note.<br><br>4. Patient #4's clinical record evidenced a comprehensive assessment performed on 1/06/25 by the CM. The comprehensive assessment visit note failed to evidence time in and time out; failed to evidence the date and time the patient signed and failed to evidence the time the CM signed the visit note.<br><br>During an interview on 2/06/25 at 10:13 AM, the CM relayed the comprehensive assessment was completed on 1/06/25 and confirmed the comprehensive assessment visit note failed to include a time in and out; failed to include a date and time the patient signed and failed to | | | |

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| | include the time the nurse signed the visit note.<br><br>5. Patient #5's clinical record evidenced a comprehensive assessment performed on 1/13/25 by the CM. The comprehensive assessment visit note failed to evidence a time in and time out; failed to evidence the date and time the patient signed and failed to evidence the time the CM signed the comprehensive assessment.<br><br>During an interview on 2/06/25 at 10:20 AM, the CM relayed the comprehensive assessment was completed on 1/13/25 for Patient #5 and confirmed the comprehensive assessment visit note failed to include a time in and out; failed to include a date and time the patient signed and failed to include the time the nurse signed the visit note.<br><br>410 IAC 17-15-1(a)(7) | | | |
| N0000 | Initial Comments | N0000 | | |

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| | This visit was for a State complaint survey of a Home Health Provider.<br><br>Survey Dates: February 3, 4, 5 and 6, 2025<br><br>Complaint: IN112454 with related and unrelated deficiencies cited.<br><br>12 Month Unduplicated Skilled Admissions: 13 | | | |
| N0458 | Home health agency administration/management<br><br>410 IAC 17-12-1(f)<br><br>Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:<br><br>(1) Receipt of job description.<br><br>(2) Qualifications.<br><br>(3) A copy of an employee's national/expanded criminal history background check pursuant to IC 16-27-2.<br><br>(4) A copy of current license, certification, or registration.<br><br>(5) Annual performance evaluations. | N0458 | N0458 Administrator/alternate administrator will ensure that all appropriate evaluations are completed yearly. Reminder will be placed in electronic chart on when evaluations are due. Personnel charts will be audited quarterly by office personnel to ensure appropriate documentation is present and updated as required. All personnel files have been reviewed to ensure compliance. | 2025-02-28 |

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| | Based on personnel file review and interview, the home health agency failed to ensure personnel files included an annual evaluation for 1 of 1 agency scheduler (Admin 4).<br><br>Findings include:<br><br>1. The undated agency policy "Personnel Records" indicated personnel files will include performance appraisals and documentation of established performance plans.<br><br>2. Admin 4's personnel file indicated a hire date of 1/13/20. The file failed to evidence an annual evaluation had been conducted.<br><br>3. During an interview on 2/06/25 at 11:38 AM, Admin 5 verified they did not complete an annual evaluation for Admin 4 within the last year. | | | |
| N9999 | Final Observations | N9999 | N9999 Administrator/alternate administrator will ensure personnel files are protected | 2025-02-28 |

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| | Authority IC 16-27-1.5-5 "Approved dementia training for home health aides"<br><br>Sec. 5 (a) This section applies to a registered home health aide who:<br><br>(1) is employed as a home health aide; and<br><br>(2) provides care to an individual who has been diagnosed with or experiences symptoms of Alzheimer's disease, dementia, or a related cognitive disorder.<br><br>(b) As used in this section, "approved dementia training" refers to a dementia training program:<br><br>(1) for use in training home health aides in the care of individuals described in subsection (a)(2); and<br><br>(2) that has been approved by the state department under subsection (f).<br><br>(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.<br><br>(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.<br><br>(e) A home health aide who:<br><br>(1) has received the training required by subsections (c) and (d);<br><br>(2) has been employed as a home health aide for at least twenty-four (24) consecutive months; and<br><br>(3) is hired by a home health agency; is not required to repeat the training required by this section.<br><br>(f) The state department shall do the following: | | against theft and loss by ensuring that the cabinet door to access the files is kept locked when files are not being accessed. | |

(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 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 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 gastrointestinal and jejunostomy tube feedings.

(e) Before January 1, 2024, the state department must approve at least one (1) training curriculum described in subsection (b).

As added by P.L.117-2023, SEC.6.

Based on observation, record review and interview, the home health agency failed to ensure personnel records were safeguarded against loss and kept in a locked storage area for 1 of 1 agency.

Findings include:

1. On 2/05/25 at 10:29 AM, observed closet door slightly open in office surveyor was working in. The closet contained 29 personnel binders.

2. On 2/06/25 at 9:10 AM, observed closet door still open in office surveyor was working in.

3. During an interview on 2/06/25 at 10:25 AM, the CM relayed the personnel files should be stored in a locked cabinet.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Deborah Joanne Abshire | RN, Director of Clinical Services | 2/24/2025 11:48:41 AM |