STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **157187**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/26/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANEW HOME HEALTH	**3830 E SOUTHPORT ROAD, SUITE 700 , INDIANAPOLIS, Indiana, 46237**

(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: 02/19/2025, 02/20/2025, 02/21/2025 and 2/262025 Active Census: 164 At this Emergency Preparedness survey, Anew Home Health was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102 QR completed by Area 3 on 3/03/2025.	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal and State licensure complaint of a home health provider. Complaint #112636 Survey Dates: 02/19/2025, 02/20/2025, 02/21/2025, and 02/26/205 Unduplicated Skilled Admissions: 164 An Immediate Jeopardy was identified on 11/15/2024 with a change noted to the patient's right heal with an increase in size from 2.2 cm to 3 cm without physician notification. On 11/22/2024 a change to the wound of the left heal to the described as a foul odor was documented and the physician was not notified. On 11/27/2024, the agency decreased visits the week of 11/24/2024-11/30/2024 to one time a week and the physician failed to be notified of the decreased visits. On 11/29/2024, the home health registered nurse recommended transfer from the ALF to an acute care hospital due to the change in wound status. The physician was not notified. The patient was hospitalized on 11/29/2024 and passed away on 01/01/2025. The cause of death on the death certificate was osteomyelitis.	G0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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G0000	Continued from page 1 The Administrator and Nursing Supervisor were notified of the Immediate Jeopardy on 02/20/2025 at 4:30 PM. The provider submitted a removal plan on 02/21/2025 at 9 AM which was found to be unacceptable, and again on 2/21/2025 at 1:47 PM which was acceptable. The Immediate Jeopardy was removed at the time of exit on 2/26/2025 at 3:45 PM. The Agency's Immediate Jeopardy removal plan and their actions were confirmed to have removed the immediacy component for the immediate jeopardy on 02/26/2025. Anew Home Health is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning 02/21/2025 through 02/20/2027 for being found out of compliance with the Conditions of Participation 42 CFR 484.50 Patient Rights, and 484.60 Care Planning, Coordination, Quality of Care. These deficiencies reflect State Findings cited in accordance with 410 IAC 17. See the State Form for State only deficiencies. Abbreviations RN Registered Nurse POC- Plan of Care SOC- Start of Care HHA- Home Health Aide LPN- Licensed Practical Nurses OASIS-a collection of standardized data elements used to assess and report on home health care patients. QR completed by Area 3 on 3/03/2025.	G0000		
G0406	Condition of Participation: Patient rights. CFR(s): 484.50 Condition of participation: Patient rights.	G0406		

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G0406	Continued from page 2 The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. This CONDITION is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure patient rights were protected; when the agency failed to ensure skilled nursing services avoided harm to the patient (see G0430), failed to ensure the patient's representative was informed of any changes in the care to be furnished (see G0434), failed to ensure proper notice was provided to the patient and/or representative of reducing services when services might be non-covered in advance of the agency reducing the service (see G0442). These practices had the potential to impact all total of 164 active home health patients serviced by the agency. The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate care and services, which could result in the agency not providing quality care. *	G0406		
G0430	Be free from abuse CFR(s): 484.50(c)(2) Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure skilled nursing services were provided to avoid harm to the patient in 1 of 2 discharged wound care patients. (Patient #1) Findings include: 1. A review of a policy titled 'PATIENT BILL OF RIGHTS Policy No. 2-002.1' stated, "… L. The right to be free from mental, physical … neglect …" 2. A review of the clinical record for Patient #1 revealed a Plan of Care dated 10/31/2024 for the	G0430		

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G0430	Continued from page 3 initial certification period of 10/31/2024 to 12/29/2024 for wound care to the medial (midline) inner buttocks 2 times a week. A skilled nursing note dated 11/5/2024 and signed by RN 4 which indicated Patient #1 had developed wounds on bilateral heels. The left heel measured at 4.2 centimeter (cm) long by 2.8 cm wide by .01 cm deep, wound bed clean, pink in color, wound edges within normal limits, a moderate amount of serosanguinous (fluid is typically pink or reddish in color and may have a thin or watery consistency. It is often seen in wounds or other areas where there is tissue damage) drainage and no odor. The right heel measured at 2.5 cm long by 2.5 cm wide and less than 0.1 cm deep wound bed clean pink in color, wound edges within normal limits, no drainage or odor noted. The narrative note indicated the wound to buttocks were improving, orders were obtained for wound care to bilateral heels and completed. A skilled nursing note dated 11/15/2024 signed by RN 3 evidenced the right heel had a measurement of 3 cm long by 1.5 cm wide by .1 cm deep, with RN 3 notifying RN 4. There was no physician's notification of the wound's change in measurement. A skilled nursing note dated 11/22/2024 signed by RN 3 evidenced a mild odor to the left lower heal, with RN 3 notifying RN 4. There was no physician's notification of the odor of the wound. A skilled nursing noted dated 11/29/2024 signed by RN 3 evidenced the left heel wound bed was eschar (a dry, dark scab or falling away of dead skin) with slough (a layer of dead, non-viable tissue that separates from the surrounding healthy tissue) 90 percent was red, 10 percent black, wound edges indistinct, with a moderate amount of sanguinous/bloody drainage, with no odor, and no measurements. RN 3 indicated the right heel wound bed eschar, 50 percent red and 50 percent black, wound edges normal, no drainage or odor noted, with the wound measuring 2 cm long by 2 cm wide and 0.1 cm deep. In the narrative notes RN 3 indicated a 2nd wound had developed on the left heel with "pus and bleeding", indicated they talked with Person 1 and Entity 2, indicated they recommended Patient 1 go to the ER. There was no physician notification. Further review of the clinical record for Patient #1 evidenced Patient Care order dated 11/20/2024 for Skilled nursing 2 times a week for 1 week with a start	G0430		

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G0430	Continued from page 4 date of 11/20/2024 to 11/23/2024. A Patient Care order dated 11/27/2024 indicated Skilled nursing 1 time a week for 1 week, and 2 times a week for 4 weeks, with the start date 11/27/2024 through 12/28/2024. A discharge OASIS was completed on 12/02/2024 which indicated Patient #1 admitted to Entity 3, an acute care hospital with osteomyelitis (an infection of the bone that causes inflammation and pain. It can occur when bacteria or other microorganisms enter the bone through an open wound) and Patient #1 was to be admitted to Hospice on 12/03/2024. 3. An admission documentation from Entity 3, an acute care hospital indicated Patient #1 was admitted on 11/29/2024 with concerns of osteomyelitis. An x-ray performed on 11/29/2024 indicated impression was "consistent with osteomyelitis involving the posterior lateral left foot". The documentation included the physician presenting Person #1, a family member with 3 options for Patient #1 due to their age, ranging from hospice to intravenous antibiotics to conservative surgery versus aggressive surgery with amputation. A review of a document titled 'INDIANA STATE DEPARTMENT OF HEALTH DEATH CERTIFICATE' dated 01/01/2025 provided by Person 1, a family member indicated the cause of death was osteomyelitis. 4. On 02/19/2025 at 1:15 PM an email correspondence with Person 1 indicated they had spoken to the wound care nurse, RN 3 directly to express the concerns and RN 3 indicated insurance would only approve 2 visits per week. On 02/21/2025at 10:45 AM an email correspondence with Person 1 indicated the agency did not notify if an increase in visits would be necessary and implied that the twice a week care was sufficient. When queried if the agency offered to teach Person 1 or others to provide additional wound care treatments, Person 1 responded, "No, no mention was made of others potentially providing additional care". On 02/20/2025 at 11:10 AM during an interview the Clinical Manager indicated they had to decrease the visits the week of 11/24/2024 through 11/30/2024, because the agency couldn't absorb the financial loss,	G0430		

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G0430	Continued from page 5 would expect to see physician notification with wound changes and further indicted Patient #1 wounds did appear to worsen from 11/05/2024 to 11/29/2024 while receiving care from the agency. 410 IAC 17-12-3(b)(4)(A)	G0430		
G0434	Participate in care CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the patient's representative was informed of any changes in the care to be furnished in 1 of 2 discharged wound care patients. (Patient #1) Findings include: 1. A review of a policy titled 'PATIENT BILL OF RIGHTS Policy no. 2-002.1' revealed "… G. Be advised in advance of any change, orally, and in writing, in the plan of care before the change is made … I. The establishment and revision of the plan of care, … any changes in the care to be furnished … S. Be informed verbally and in writing of any changes in payment information as soon as possible, in advance of the next	G0434		

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G0434	Continued from page 6 home visit, that the organization becomes aware of the change. 2. A review of the clinical record for Patient #1 revealed a Plan of Care dated 10/31/2024 for the certification period of 10/31/2024 to 12/29/2024 for wound care to the medial (midline) inner buttocks 2 times a week. Further review of the clinical record for Patient #1 evidenced Patient Care order dated 11/20/2024 for Skilled nursing 2 times a week for 1 week with a start date of 11/20/2024 to 11/23/2024. A Patient Care order dated 11/27/2024 indicated Skilled nursing 1 time a week for 1 week, and 2 times a week for 4 weeks, with the start date 11/27/2024 through 12/28/2024. 3. On 02/19/2025 at 9:35 AM during a interview with Person 1, a family member to Patient #1 indicated as far as they were aware visits were conducted 2 times a week. On 02/20/2025 at 10:45 AM an email correspondence with Person 1 indicated the agency gave no information related to a need for increased visits for wound care, it was implied the twice a week care was sufficient. Further indicated if the agency had mentioned more frequent care was required, they would have argued with insurance to provide the additional coverage or would have paid out of pocket for the care if insurance refused. When queried if the agency offered to teach Person 1 or others to provide additional wound care treatments, Person 1 responded, "No, no mention was made of others potentially providing additional care". On 02/20/2025 at 11:10 AM during an interview with the Clinical Manager, when queried if they had spoken to Person 1 about the decrease in service or to ask if they would be willing to pay privately, they indicated the decrease in services was not communicated with the representative, and the agency doesn't typically accept private pay, it would have to be discussed well in advance, communicate with the power of attorney of treatment and fees, and skilled nursing would have had to teach others to care for the wound. 410 IAC 17-12-3(b)(2)(D)(i)(AA)	G0434		
G0442	Written notice for non-covered care	G0442		

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G0442	Continued from page 7 CFR(s): 484.50(c)(8) Receive proper written notice, in advance of a specific service being furnished, if the HHA believes that the service may be non-covered care; or in advance of the HHA reducing or terminating on-going care. The HHA must also comply with the requirements of 42 CFR 405.1200 through 405.1204. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the Agency failed to ensure proper notice was provided to the patient and/or representative of a reduction in services when services might be non-covered in 1 of 2 discharged record reviews. (Patient #1) Findings include: 1. A review of a policy titled 'FINANCIAL RESPONSIBILITY Policy no. 2-007.1 stated, "… 5. All written and verbal notifications of the patient's financial responsibility will be documented in the clinical/service records …" A review of a policy titled 'Patient Notification of Changes in Care Policy No. 4-014.1' stated, "… POLICY The patient will be notified within 24 hours with any significant changes in the agreed upon … plan of care … Plan of Care Changes … 2. Documentation of the notification will include: A. Date and Time … Specific Changes … Patient response or acceptance …" 2. A review of the clinical record for Patient #1 revealed a Plan of Care dated 10/31/2024 for the initial certification period of 10/31/2024 to 12/29/2024 for wound care to the medial (midline) inner buttocks 2 times a week. A skilled nursing note dated 11/5/2024 and signed by RN 4 which indicated Patient #1 had developed wounds on bilateral heels. The left heel measured at 4.2 centimeter (cm) long by 2.8 cm wide by .01 cm deep, wound bed clean, pink in color, wound edges within normal limits, a moderate amount of serosanguinous (fluid is typically pink or reddish in color and may have a thin or watery consistency. It is often seen in wounds or other areas where there is tissue damage) drainage and no odor. The right heel measured at 2.5 cm long by 2.5 cm wide and less than 0.1 cm deep wound bed clean pink in color, wound edges within normal limits, no drainage or odor noted. The	G0442		

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G0442	Continued from page 8 narrative note indicated the wound to buttocks were improving, orders were obtained for wound care to bilateral heels and completed. Further review of the clinical record for Patient #1 evidenced a Patient Care order dated 11/27/2024 indicated Skilled nursing 1 time a week for 1 week, and 2 times a week for 4 weeks, with the start date 11/27/2024 through 12/28/2024, with no explanation as to why the order was written for 1 time a week for 1 week. The record failed to evidence patient/representative notification of the change in service from 2 times a week to 1 time a week. 3. On 02/21/2025 at 10:45 AM an email correspondence with Person 1, indicated if the agency had mentioned more frequent care was required, they would have argued with insurance to provide the additional coverage or they would have paid out of pocket for the care if insurance refused. When queried if the agency offered to teach Person 1 or others to provide additional wound care treatments, Person 1 responded, "No mention was made of others potentially providing additional wound care". On 02/20/2025 11:10 AM the Clinical Manager indicated there was a decrease in frequency with Patient #1's service, because the authorization didn't pay, and when queried if they had spoken to Patient #1's representative about the decrease in service or to ask if they would be willing to pay privately, they indicated the decrease in services was not communicated with the representative and typically they don't accept private pay unless it's discussed ahead of time, with the Power of Attorney or representative notified regarding fees, and teaching would had to occurred.	G0442		
G0514	RN performs assessment CFR(s): 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return	G0514		

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G0514	Continued from page 9 home, or on the physician or allowed practitioner - ordered start of care date. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the initial assessment was completed within 48 hours of the referral in 2 of 6 active record reviews (Patients #3 and 5) and 1 of 2 closed records reviewed. (Patient #1) Findings include: 1. A review of a policy titled 'ADMISSION CRITERIA AND PROCESS Policy No 2-003.1' stated, "… PROCEDURE … 2. The Clinical Supervisor will assign clinical organization personnel to conduct initial assessments … within 48 hours of acceptance of referral information …" 2. A review of the closed clinical record for Patient #1 evidenced a document titled 'Referral' with the referral date of 10/24/2024 with Patient #1 identified. Further review of the clinical record evidenced a document titled 'Home Health Certification and Plan of Care' which indicated the start of care date was 10/31/2024 with the initial assessment completed on 10/31/2024. The record failed to contain communication notes or physician notification of the late assessment. 3. A review of the clinical record for Patient #3 evidenced a document titled 'Referral' with the referral date of 01/03/2025 with Patient #3 identified. Further review of the clinical record evidenced a document titled 'Home Health Certification and Plan of Care' which indicated Patient #3 start of care date was 01/14/2025 with the initial assessment completed on 01/14/2025. The record failed to contain communication notes or physician notification of the late assessment. 4. A review of the clinical record for Patient #5 evidenced a document titled 'Referral' with the referral date of 02/13/2025 with Patient #5 identified. Further review of the clinical record evidenced a document titled 'Home Health Certification and Plan of Care' which indicated the start of care date was 02/18/2025 with the initial assessment completed on 02/18/2025. The record failed to contain communication notes or physician notification of the late assessment.	G0514		

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G0514	Continued from page 10 5. On 02/19/2025 at 1:54 PM during an interview with Person 7, a family member to Patient #5 indicated the agency was to start wound care on 02/13/2025, but received a call indicating they would be there on 02/17/2025 to start services but didn't start until 02/18/2025. On 02/19/2025 at 10:15 AM Person 1, a family member to Patient #1, indicated they had no idea why services didn't get started for Patient #1 prior to 10/31/2024. On 02/21/2025 at 12:48 PM the Administrator indicated it was the agency's policy to not admit patients until the face to face was completed and "everything was in place". When queried about what was everything, they indicated insurance, the face to face, staff, everything we're required to have prior to starting the case. 410 IAC 17-14-1(a)(1)(A)	G0514		
G0570	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. This CONDITION is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure the ordered frequency of services was followed, the agency failed to ensure patients received	G0570		

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NAME OF PROVIDER OR SUPPLIER: ANEW HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE: 3830 E SOUTHPORT ROAD, SUITE 700 , INDIANAPOLIS, Indiana, 46237		

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G0570	Continued from page 11 services ordered in the plan of care, and failed to ensure the physician had been notified when scheduled visits for wound care were missed reviewed (see G0572), failed to ensure the individualized plan of care included all orders, supplies and equipment, and rehab potential (see G0574), failed to ensure physician orders were in place prior to performing catheter care treatment and catheter changes (see G0580), the agency failed to ensure nursing staff notified ordering provider of a change in condition in a patient's wound (G0590), failed to coordinate care amongst all agency members (see G0606), failed to ensure patient clinical records included information about the services the patient received from other agencies and failed to ensure they coordinated care delivery to meet the patient’s needs (see G0608). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation at 42 CFR 484.60 Care Planning, Coordination of Care, Quality of Care, with the likelihood to affect all 164 active current patients receiving Home Health services from this provider. Findings include: An immediate jeopardy was identified and announced on 02/20/2025 at 4:30 PM related to 42 CFR §484.60: Care planning, coordination of services, and quality of care. The immediate jeopardy was identified as beginning on 11/25/2024.01/14/2025. The Immediate Jeopardy was removed at the time of exit on 02/26/2025. The Agency's Immediate Jeopardy removal plan and their actions were confirmed to have removed the immediacy component for the immediate jeopardy on 02/26/2025. 1. A review of an agency policy reviewed April 2020, titled 'CARE/SERVICE COORDINATION' stated, "… PURPOSE To ensure the coordination of services for each patient … It will be the responsibility of the Case Manager to facilitate communication about changes in the patient status among assigned personnel. Timely and ongoing communication is the responsibility of each team member of the interdisciplinary group …" A review of agency policy reviewed April 2020, titled 'MONITORING PATIENT'S RESPONSE/REPORTING TO PHYSICIAN' stated, "… 3. The patient's physician will be contacted	G0570		

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G0570	Continued from page 12 on the same day when any of the following occur: … A. Significant changes in the patient's condition … C. Changes in the patient's expected response to treatment … E. When there is any problem implementing the plan of care … G. When a visit is missed for any reason …" 2. A review of the clinical record for Patient #1 revealed a Plan of Care dated 10/31/2024 for the certification period of 10/31/2024 to 12/29/2024 for wound care to the medial (midline) inner buttocks 2 times a week. A skilled nursing note dated 11/5/2024 and signed by RN 4 which indicated Patient #1 had developed wounds on bilateral heels. The left heel measured at 4.2 centimeter (cm) long by 2.8 cm wide by .01 cm deep, wound bed clean, pink in color, wound edges within normal limits, a moderate amount of serosanguinous (fluid is typically pink or reddish in color and may have a thin or watery consistency. It is often seen in wounds or other areas where there is tissue damage) drainage and no odor. The right heel measured at 2.5 cm long by 2.5 cm wide and less than 0.1 cm deep wound bed clean pink in color, wound edges within normal limits, no drainage or odor noted. The narrative note indicated the wound to buttocks were improving, orders were obtained for wound care to bilateral heels and completed. A skilled nursing note dated 11/15/2024 signed by RN 3 evidenced the right heel had a measurement of 3 cm long by 1.5 cm wide by .1 deep, with RN 3 notifying RN 4 and a skilled nursing note dated 11/22/2024 signed by RN 3 evidenced a mild odor to the left lower heal, with RN 3 notifying RN 4. The record failed to evidence MD notification of the 2 skilled nursing visits with a change in the wound. A skilled nursing noted dated 11/29/2024 signed by RN 3 evidenced the left heel wound bed with eschar (a dry, dark scab or falling away of dead skin) and slough (a layer of dead, non-viable tissue that separates from the surrounding healthy tissue) 90 percent was red, 10 percent black, wound edges indistinct, with a moderate amount of sanguineous/bloody drainage, with no odor, and no measurements. RN 3 indicated the right heel wound bed eschar, 50 percent red and 50 percent black, wound edges normal, no drainage or odor noted, with the wound measuring 2 cm long by 2 cm wide and 0.1 cm deep. In the narrative notes RN 3 indicated a 2nd wound had developed on the left heel with "pus and bleeding", indicated they talked with Person 1 and Entity 2, indicated they recommended Patient 1 go to the	G0570		

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G0570	Continued from page 13 emergency room (ER). The record failed to evidence MD notification of the wound change and of recommendation of going to the ER. An order was written on 11/20/2024 for skilled nursing 2 times a week for 6 weeks with a start date of 11/20/2024 requesting authorization. On 11/27/2024 an order was written for skilled nursing for 1 time a week for 1 week, then 2 times a week for 4 weeks, since there was no authorization for the week of 11/24/2024 through 11/30/2024. The physician was unaware of the decrease in frequency. 3. On 11/29/2024 Patient #1 was admitted to Entity 3, an acute care hospital with a diagnosis of osteomyelitis (an infection of the bone that causes inflammation and pain. It can occur when bacteria or other microorganisms enter the bone through an open wound). 4. An agency discharge OASIS was completed on 12/02/2024 which indicated Patient #1 was admitted to Entity 3, an acute care hospital with osteomyelitis and Patient #1 was to be admitted to Hospice on 12/03/2024. Entity 3's admission documentation indicated the left posterior heel was unstageable, approximately 2.0 cm by 2.0 cm. The wound bed was covered with 100% thick yellow slough and brown eschar, moderate amount of serous drainage, malodor, periwound with maceration and erythema. The left lateral heel measured 3.0 cm by 2.0 cm by 0.4 cm. The wound bed was 100% thick yellow slough, serous drainage, malodor, periwound with maceration and erythema. The right heel was unstageable. The wound measured approximately 2.0 cm by 2.0 cm. The wound bed was completely covered with black eschar with no drainage, no odor, and periwound was intact. Person 5, a DPM from Entity 3 indicated options for Patient #1 would range from hospice to IV antibiotics to conservative surgery versus aggressive surgery with amputation. A review of a document titled 'INDIANA STATE DEPARTMENT OF HEALTH DEATH CERTIFICATE' dated 01/01/2025 provided by Person 1 indicated the cause of death was osteomyelitis. 4. On 02/20/2024 email correspondence with Person 1	G0570		

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G0570	Continued from page 14 indicated the agency never indicated more visits would be needed for wound care, it was implied twice a week care was sufficient. Further indicated if the agency had mentioned more frequent care was required, they would have argued with insurance to provide the additional coverage or would have paid out of pocket for the care if insurance refused. When queried if the agency offered to teach Person 1 or others to provide additional wound care treatments, Person 1 responded, "No, no mention was made of others potentially providing additional care". On 02/20/2025 during an interview with the Clinical Manager when queried if they had spoken with Patient #1's representative about the decrease in service or ask if they would be willing to pay privately, they indicated the decrease in services was not communicated with the representative, and the agency doesn't typically accept private pay, it would have to be discussed well in advance, communicate with the power of attorney of treatment and fees, and teach others to care for the wound, indicated the wounds had worsened since 11/05/2024 and had to decrease the visits the week of 11/24/2024 through 11/30/2024, because the agency couldn't absorb the financial loss and they expected nurses to reach out to the clinical managers and physicians when there is a change with a patient.	G0570		
G0572	Plan of care CFR(s): 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure the ordered frequency of services was followed, in 2 of 2 active records with frequencies not followed, (Patients #3 and #5), the agency failed to ensure patients received services ordered in the plan of care, in 1 of 1 closed record reviewed with services	G0572		

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G0572	Continued from page 15 not received (Patient #4), and failed to ensure the physician had been notified when scheduled visits for wound care were missed (Patients #3 and #4) in 1 of 1 active records with missed visits reviewed, and 1 of 1 closed records with missed visits reviewed (Patient #4), in total sample of 6 active records and 2 closed records reviewed. Findings include: 1. A review of an agency policy reviewed April 2020, titled 'MISSED VISITS' stated, "… Missed visits will be communicated to the clinical supervisor and the patient's physician. A missed visit will be rescheduled the same week if possible. Missed visits will be documented in the clinical record … 1. If a visit is missed for any reason, the clinician should attempt to reschedule it for the same week, so that the physician ordered frequency is maintained and would not be considered a missed visit. 2. If a visit is missed and not rescheduled the clinician will: A. Notify the physician and clinical supervisor of the missed visit and reason for the reason for the missed visit. B. Document in the patient's clinical record the following information: … 3. Reason for the missed visit … 4. Description of any unmet needs and how the patient's needs were met … 5. Physician notification including date, time, physician name, method of notification and the staff reporting information … 7. Other person(s) that were notified of the missed visit …" 2. A review of the clinical record for Patient #4 with a start of care date of 12/13/2024 and an initial certification period of 12/13/2024 to 02/10/2025 evidenced skilled nursing visits were ordered 1 time per week for 1 week, 2 times per week for 2 weeks, then 1 time per week for 1 week, to perform wound care to a diabetic ulcer of the left lower leg. Wound care orders stated, "… SN (Skilled Nurse) to cleanse wound with NS (normal saline), apply Hydrafera blue (an antibacterial wound dressing). Wrap in Kerlex (a type of gauze bandage) and secure with Coban (a type of self-adhering bandage) 1 time weekly until healed. Patient educated to change every other day when SN not present …" A review of the skilled nursing visit notes for Patient #4 evidenced a scheduled Nursing Visit for wound care was missed on 12/31/2024 by RN 2 for the week of 12/29/2024.	G0572		

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G0572	Continued from page 16 A review of the communication notes for Patient #4 failed to evidence communication had been made with the Clinical Supervisor, the ordering physician, or a family representative regarding the missed skilled nursing visit for wound care on 12/31/2024. Further review of the record for Patient #4 failed to evidence an attempt had been made to reschedule the missed skilled wound care visit on 12/31/2024 for later date in the same Medicare week, and evidenced a Transfer OASIS had been completed on 01/05/2025, which indicated the patient had been admitted to the hospital on 01/03/2025 after a fall. 3. On 02/20/2025 at 10:45 AM, during an interview the Clinical Supervisor reviewed the missed visit note of 12/31/2024 for Patient# 4, but saw no other related documentation and indicated she expected attempts to reach the patient and reschedule visit would be documented. Indicated the agency had educated clinicians to document the reason for missed visits. Further indicated, "we need to be documenting we reached out to emergency contacts and to providers". The clinical manager indicated was not aware of this matter before today. "We need to make attempts to see them again" and call the MD, the wound clinic, etc. On 02/20/2025 at 3:36 PM, in a telephone interview, RN 2 indicated when a scheduled wound care visit is missed, he/she would try to call the patient and leave a voicemail or text, would reach out to the patient's emergency contact, "call my boss [Clinical Manager]" and indicated the Clinical Manager could try to reach patient, would perform a 'drive-by' and go to the patient's home, and if no contact was made stated, "I will call 911". When queried as to the missed visit for Patient #4 on 12/31/2024, RN 2 indicated there had always been a problem with access the 'community' where the patient resided, citing troubles with the gaining access through a secured door. Indicated the manager of the community would not let him/her into the building. RN 2 indicated had tried to call the patient's emergency contact, and stated "I told [Clinical Manager]". RN 2 further indicated had made contact with family member and with the MD, but had not documented this. When queried regarding rescheduling a wound care visit for later in the week, RN 2 indicated sometimes they might reschedule a visit for later in the week, and sometimes for the next week, referred again to the difficulties they had gaining entry into the building, and indicated next time would make sure communication	G0572		

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G0572	Continued from page 17 note was updated, and felt they should have documented about the building manager not allowing access. 4. A review of the clinical record for Patient #3 evidenced a document dated 12/30/2024 from Entity 10, a wound care clinic which was faxed to the agency on 01/02/2025, indicating the need for home care services for wound care 3 times a week, with the Agency to reply if the Agency was unable to accept patient. Further review of the clinical record for Patient #3 evidenced a communication note on 01/03/2025 indicated the Agency could not staff 3 times a week. Patient #3's record evidenced a Patient Care Order (Verbal Order) was obtained on 01/14/2025 effective 01/14/2025 which revealed but not limited to "3. Decubitus/Pressure Ulcer Stage III Bilateral Buttock Decubitus/Pressure Ulcer Stage III/Right Buttocks perform wound care/dressing change: Cleanse with NS [normal saline] or wound cleanser. Apply purachol plus AG+ (a wound dressing that contains collagen and silver to help heal wounds) as a filler. Apply aquacel ag advantage (a sterile, antimicrobial dressing used to treat acute and chronic wounds that are infected or at risk of infection). And secure with Allevyn (a sterile, absorbent foam dressing used to treat wounds) dressing. SN to perform 2 times a week". A review of the skilled nursing visit notes for Patient #3 evidenced visits were not completed on the following dates and were without physician notification: 01/31/2025 by RN 6, 02/06/2025 by RN 6, 02/07/2025 by RN 6, and 02/12/2025 by RN 6. On 02/19/2025 at 12:47 PM during an interview with RN 6 indicated nurses should always notify the physician of missed visits. When asked if they had reached out to the physician for Patient #3 of missed visits, they could not recall. On 02/19/2025 at 10:55 AM during an interview the Administrator indicated they would expect to see missed visits documented along with the physician notification. 5. A review of the clinical record for Patient #5	G0572		

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G0572	Continued from page 18 evidenced a communication note for 02/13/2025 at 4:40 PM indicated LPN 2 obtained a verbal order for skilled nursing for wound care 2 times a week, a clarification of a written order for skilled nursing services 3 times a week. On 02/21/2025 at 10:05 AM Person 9, the Registered Nurse for Person 8 indicated the original order for Patient #5 was for wound care 3 times a week and confirmed the patient was not going to a wound clinic. On 02/21/2025 LPN 2 9:30 AM indicated the Agency did not have adequate staff to service Patient #5 to staff 3 times a week, so they reached out to obtain a verbal order to change the frequency. On 02/21/2025 at 8:45 AM when queried the Administrator about the reduction in frequency with Patient #5, the Administrator indicated if a patient needed to be seen 3 times a week, they would be seen. The Administrator indicated most times when an order is written for skilled nursing wound care 3 times a week, the patient usually goes to a wound clinic one of those days, so the patient is actually staffed 2 times a week from the Agency. When asked as to why Patient #5's order was changed from 3 times a week to 2 times a week since they were not going to a wound care clinic, they did not provide an answer. 410 IAC 17-13-1(a)	G0572		
G0574	Plan of care must include the following CFR(s): 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;	G0574		

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G0574	Continued from page 19 (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the individualized plan of care included all orders, supplies and equipment, and rehab potential for 1 of 6 active records reviewed. (Patient: #6) Findings Include: 1. A review of an agency policy reviewed March 2023, titled “CARE PLANNING PROCESS” indicated but was not limited to, “ … To provide clinical direction to the clinicians providing direct patient care … The patient-specific clinical plan of care includes: … All patient are orders including verbal orders … Supplies and equipment required … Rehabilitation potential … ” 2. During a home visit at Patient #6’s residence, on 02/21/2025 at 10:30 AM, observed Patient #6 laying on a blue chuck in a hospital bed with an airflow mattress. The patient used a reacher to pick up a tissue off the floor and discarded it in the trash bag hanging off the bed’s side rail. Patient #6 had a wooden slide board in	G0574		

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G0574	Continued from page 20 his wheelchair next to the bed for transferring. RN 4 performed wound care to Patient #6's right buttock wound. The RN then assessed Patient #6's suprapubic catheter insertion site (a hollow flexible tube that's inserted in the abdomen used to drain urine from the bladder) and indicated Patient #6's site was excoriated. RN 4 obtained antifungal cream and a 4x4 gauze dressing. RN 4 cut a slit in the 4x4 gauze, applied an antifungal cream to the gauze, then applied the dressing to Patient #6's suprapubic catheter insertion site. A review of the clinical record for Patient #6 contained a POC for the recertification period of 12/24/2024 to 02/21/2025. The POC indicated a primary diagnosis of Pressure Ulcer of Right Buttock Stage 4 (most serious sore extending to deep tissue and may reach cartilage and bone), and other pertinent diagnoses included Acquired Absence of Right Leg Above the Knee, Acquired Absence of Left Leg Above knee, and Encounter for Fitting and Adjustment of Urinary Device, and Encounter for Attention to Cystostomy (a surgical procedure creating an opening in the urinary bladder to drain urine creating a stoma on the lower abdomen). The section titled "Supplies" listed wheelchair, wound care supplies and catheter supplies, but failed to list the patient's reacher, slide board, hospital bed, specialty air flow mattress, chucks, and specific catheter supplies required. The section titled "Orders/Treatments" indicated Patient #6 had orders for skilled nursing two times a week for one week, then 3 times a week for 8 weeks to cleanse wound with normal saline, pat dry, paint peri-wound skin with betadine or gentian violet, apply Prisma dressing to wound bed, moistened with normal saline if wound bed is dry, cover with silver alginate dressing, a folded dry gauze, and cover with a Mepilex foam dressing, and assess wound status 3 times a week and as needed. The POC failed to evidence orders for suprapubic catheter insertion site care or catheter changes. The section titled "Rehab" indicated not applicable. During an interview on 02/21/2025 at 10:35 AM, the Clinical Manager confirmed they reviewed and signed off on the completed POCs for accuracy and completion. 3. During an interview on 02/21/2025 at 11:35 AM, RN 4 confirmed all orders should had been on the POC, and catheter changes and catheter site treatment had not been listed as orders on the POC. 410 IAC 17-13-1(a)(1)(C)(ii,v,xii)	G0574		
G0580	Only as ordered by a physician	G0580		

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G0580	Continued from page 21 CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the skilled nurses failed to ensure physician orders were in place prior to performing catheter care treatment and catheter changes to 1 of 1 active clinical records reviewed of patients with catheters. (Patient: #6) Findings Include: 1. A review of an agency policy reviewed March 2023, titled “VERIFICATION OF PHYSICIAN ORDERS” indicated but was not limited to, “ … Verbal orders will be obtained from a licensed physician … for care and services to be provided to home health patients … ” 2. During a home visit at Patient #6’s residence, on 02/21/2025 at 10:30 AM, observed RN 4 perform wound care to Patient #6’s right buttock wound. RN 4 then assessed Patient #6’s suprapubic catheter insertion site (a hollow flexible tube that's inserted in the abdomen used to drain urine from the bladder) and indicated Patient #6’s site was excoriated. RN 4 obtained antifungal cream and a 4x4 gauze dressing. RN 4 cut a slit in the 4x4 gauze, applied an antifungal cream to the gauze, then applied the dressing to Patient #6’s suprapubic catheter insertion site. A review of the clinical record for Patient #6 contained a POC for the recertification period of 12/24/2024 to 02/21/2025. The POC indicated a primary diagnosis of Pressure Ulcer of Right Buttock Stage 4 (most serious sore extending to deep tissue and may reach cartilage and bone), and other pertinent diagnoses included Acquired Absence of Right Leg Above the Knee, Acquired Absence of Left Leg Above Knee, and Encounter for Fitting and Adjustment of Urinary Device, and Encounter for Attention to Cystostomy (a surgical procedure creating an opening in the urinary bladder to drain urine creating a stoma on the lower abdomen). Patient #6 had orders for skilled nursing two times a week for one week, then 3 times a week for 8 weeks to cleanse wound with normal saline, pat dry, paint peri-wound skin with betadine or gentian violet, apply Prisma dressing to wound bed, moistened with normal saline if wound bed is dry, cover with silver alginate dressing, a folded dry gauze, and cover with a Mepilex foam dressing, and assess wound status 3 times a week	G0580		

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NAME OF PROVIDER OR SUPPLIER **ANEW HOME HEALTH**	STREET ADDRESS, CITY, STATE, ZIP CODE **3830 E SOUTHPORT ROAD, SUITE 700 , INDIANAPOLIS, Indiana, 46237**		

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G0580	Continued from page 22 and as needed. The POC failed to evidence orders for suprapubic catheter insertion site care or catheter changes. A review of the skilled nurses notes electronically signed by LPN 1 and dated 12/25/2024 through 02/19/2025 evidenced the following: On 01/01/2025, LPN 1 had documented in the section titled, “Narrative Notes” changed Patient #6’s suprapubic catheter. The LPN used a 16 French catheter with a 10 cc balloon anchored per sterile technique without difficulty with immediate yellow urine return. On 01/10/2025, LPN 1 had documented in the section titled, “Narrative Notes” changed Patient #6’s suprapubic catheter. The LPN used a 16 French catheter with a 10 cc balloon anchored per sterile technique without difficulty with immediate yellow urine return. On 01/31/2025, LPN 1 had documented in the section titled, “Narrative Notes” changed Patient #6’s suprapubic catheter. The LPN used a 16 French catheter with a 10 cc balloon anchored per sterile technique without difficulty with immediate yellow urine return. On 02/14/2025, LPN 1 had documented in the section titled, “Narrative Notes” changed Patient #6’s suprapubic catheter. The LPN used a 16 French catheter with a 10 cc balloon anchored per sterile technique without difficulty with immediate yellow urine return. During an interview on 02/21/2025 at 11:35 AM, when queried regarding the plan of care or updated order for Patient #6's treatment to suprapubic catheter site and catheter changes, RN 4 the case manager for Patient #6, indicated Patient #6 did not have orders for a treatment to suprapubic catheter site or catheter changes. RN 4 further indicated they were unaware LPN 1 had completed catheter changes for Patient #6. The Clinical Manager monitoring RN 4's visit confirmed it is required to have a physician order to complete catheter insertion site care and catheter changes. 410 IAC 17-13-1(a)	G0580		
G0590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care	G0590		

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G0590	Continued from page 23 should be altered. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure nursing staff notified the relevant provider of a change in condition in a patient's wound in 1 of 1 discharge record with change in condition (Patient #1) and 2 of 2 of active records with a change in condition reviewed. (Patients #3 and 6) Findings include: 1. A review of agency policy reviewed April 2020, titled 'MONITORING PATIENT'S RESPONSE/REPORTING TO PHYSICIAN' stated, "… 3. The patient's physician will be contacted on the same day when any of the following occur: … A. Significant changes in the patient's condition … C. Changes in the patient's expected response to treatment … E. When there is any problem implementing the plan of care … G. When a visit is missed for any reason …" 2. A review of the clinical record for Patient #1 revealed a Plan of Care dated 10/31/2024 for the initial certification period of 10/31/2024 to 12/29/2024 for wound care to the medial (midline) inner buttocks 2 times a week. A skilled nursing note dated 11/5/2024 and signed by RN 4 which indicated Patient #1 had developed wounds on bilateral heels. The left heel measured at 4.2 centimeter (cm) long by 2.8 cm wide by .01 cm deep, wound bed clean, pink in color, wound edges within normal limits, a moderate amount of serosanguinous (fluid is typically pink or reddish in color and may have a thin or watery consistency. It is often seen in wounds or other areas where there is tissue damage) drainage and no odor. The right heel measured at 2.5 cm long by 2.5 cm wide and less than 0.1 cm deep wound bed clean pink in color, wound edges within normal limits, no drainage or odor noted. The narrative note indicated the wound to buttocks were improving, orders were obtained for wound care to bilateral heels and completed. A skilled nursing note dated 11/15/2024 signed by RN 3 evidenced the right heel had a measurement of 3 cm long by 1.5 cm wide by .1 deep, with RN 3 notifying RN 4. The record failed to evidence MD notification of the wound change.	G0590		

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G0590	Continued from page 24 A skilled nursing note dated 11/22/2024 signed by RN 3 evidenced a mild odor to the left lower heal, with RN 3 notifying RN 4. The record failed to evidence MD notification of the wound change. A skilled nursing noted dated 11/29/2024 signed by RN 3 evidenced the left heel wound bed was eschar (a dry, dark scab or falling away of dead skin) with slough (a layer of dead, non-viable tissue that separates from the surrounding healthy tissue) 90 percent was red, 10 percent black, wound edges indistinct, with a moderate amount of sanguinous/bloody drainage, with no odor, and no measurements. RN 3 indicated the right heel wound bed eschar, 50 percent red and 50 percent black, wound edges normal, no drainage or odor noted, with the wound measuring 2 cm long by 2 cm wide and 0.1 cm deep. In the narrative notes RN 3 indicated a 2nd wound had developed on the left heel with "pus and bleeding", indicated they talked with Person 1, a family member and Entity 2, indicated they recommended Patient 1 go to the emergency room (ER). The record failed to evidence MD notification of the wound change and of recommendation of going to the ER 3. A review of the clinical record for Patient #3 evidenced a Home Health Care Certification and Plan of Care dated 01/14/2025 for the initial certification period of 01/14/2025 through 03/14/2025 which indicated skilled nursing visits for wound care was to be performed 2 times a week for wounds to but not limited to both sides of the abdomen, to coccyx, Stage II pressure area, and right buttock, Stage III pressure area. A review of clinical notes for Patient #3 evidenced on 01/17/2025 signed by RN 1, the right buttock measured at 0.8 cm by 0.8 cm by 0.1 cm. On 01/22/2025 signed by RN 6, the right buttock measured at 1.0 cm by 1.2 cm by 0.1 cm, indicated no one contacted as a result of the visit. The record failed to evidence MD notification of the wound change. 4. On 02/20/2025 at 8:32 AM during an interview with RN 3 indicated MD notification would occur with patient changes, if they lived in a facility, would contact the nurse in charge, and would contact family members as well. When queried if they contacted the physician with Patient #1, they indicated they could not remember.	G0590		

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G0590	Continued from page 25 On 02/19/2025 at 12:47 PM RN 6 indicated they would contact the physician with any wound changes. When queried if they had contacted physician for Patient #3 from the visit on 01/22/2025, they could not recall. On 02/19/2025 at 10:55 AM during an interview the Administrator indicated they would expect to see changes with the patient documented with physician notification. 5. A review of the clinical record for Patient #6 contained a POC for the recertification period of 12/24/2024 to 02/21/2025. The POC indicated a primary diagnosis of Pressure Ulcer of Right Buttock Stage 4 (most serious sore extending to deep tissue and may reach cartilage and bone). Patient #6 had orders for skilled nursing two times a week for one week, then 3 times a week for 8 weeks to cleanse wound with normal saline, pat dry, paint peri-wound skin with betadine or gentian violet, apply Prisma dressing, moisten wound bed with normal saline if wound bed is dry, cover with silver alginate dressing, folded dry gauze, and cover with a Mepilex foam dressing, and assess wound status 3 times a week and as needed. A review of the skilled nurses notes electronically signed by LPN 1, dated 12/25/2024 through 02/19/2025 evidenced the following: On 01/08/2025, LPN 1 documented Patient #6's right buttocks wound size as 1.6 centimeters (cm) x 0.2 cm x 0.2 cm. On 01/10/2025, LPN 1 documented noted an increase in Patient #6's right buttocks wound size to 1.7 cm x 0.2 cm x 0.2 cm. The skilled note failed to evidence the LPN notified the RN or physician of the increased wound size. On 02/12/2025, LPN 1 documented Patient #6's right buttocks wound size as 1.5 cm x 0.2 cm x 0.2 cm. On 02/14/2025, LPN 1 documented observed macerated wound edges, noted a decline in wound status, and recorded Patient #6's right buttocks wound size as 1.7cm x 0.2 cm x 0.2 cm. The note failed to evidence the LPN notified the RN or physician of the increased wound size and changes in the wound. A review of the communication notes dated 12/25/2024 through 02/19/2025 failed to evidence the physician had been notified of the changes in Patient #6's wound.	G0590		

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G0590	Continued from page 26 During an interview on 02/21/2025 at 11:35 AM, when asked about the agency policy regarding wound changes and patient changes in condition processes for LPN reporting, RN 4, the case manager for Patient #6, indicated LPN 1 should have reported the wound changes to the RN. RN 4 indicated the RN and LPN should have documented changes in Patient #6's wound in the communication notes directing the LPN to call the physician for new orders if necessary. 410 IAC 17-13-1(a)(2)	G0590		
G0606	Integrate all services CFR(s): 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to coordinate care amongst all agency members in 1 of 1 active clinical records reviewed with care being provided by a LPN. (Patient: #6) Findings Include: 1. A review of an agency policy reviewed April 2020, titled "CARE/SERVICE COORDINATION" indicated but was not limited to, " … It will be the responsibility of the Case Manager to facilitate communication about changes in the patient status among assigned personnel. Timely and ongoing communication is the responsibility of each team member of the interdisciplinary group … The clinician will be responsible for facilitating communications about changes in the patent's status among the assigned personnel … " 2. A review of the clinical record for Patient #6 contained a POC for the recertification period of 12/24/2024 to 02/21/2025. The POC indicated a primary diagnosis of Pressure Ulcer of Right Buttock Stage 4 (most serious sore extending to deep tissue and may reach cartilage and bone). Patient #6 had orders for skilled nursing two times a week for one week, then 3 times a week for 8 weeks to cleanse wound with normal saline, pat dry, paint peri-wound skin with betadine or gentian violet, apply Prisma dressing, moisten wound bed with normal saline if wound bed is dry, cover with	G0606		

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G0606	Continued from page 27 silver alginate dressing, folded dry gauze, and cover with a Mepilex foam dressing, and assess wound status 3 times a week and as needed. A review of the skilled nurses notes electronically signed by LPN 1, dated 12/25/2024 through 02/19/2025 evidenced the following: On 01/01/2025, LPN 1 had documented in the section titled, “Narrative Notes” changed Patient #6’s suprapubic catheter. The LPN used a 16 French catheter with a 10 cc balloon anchored per sterile technique without difficulty with immediate yellow urine return. The section titled “Visit Plan-Communication” indicated no one contacted as a result of this visit. The skilled note failed to evidence the LPN notified the RN of orders needed for catheter change. On 01/10/2025, LPN 1 noted an increase in Patient #6's right buttocks wound size to 1.7 cm x 0.2 cm x 0.2 cm. The section titled “Visit Plan-Communication” indicated no one contacted as a result of this visit. LPN 1 had documented in the section titled, “Narrative Notes” changed Patient #6’s suprapubic catheter. The LPN used a 16 French catheter with a 10 cc balloon anchored per sterile technique without difficulty with immediate yellow urine return. The section titled “Visit Plan-Communication” indicated no one contacted as a result of this visit. The skilled note failed to evidence the LPN notified the RN of the increased wound size and the orders needed for catheter change. On 01/31/2025, LPN 1 had documented in the section titled, “Narrative Notes” changed Patient #6’s suprapubic catheter. The LPN used a 16 French catheter with a 10 cc balloon anchored per sterile technique without difficulty with immediate yellow urine return. The section titled “Visit Plan-Communication” indicated no one contacted as a result of this visit. The skilled note failed to evidence the LPN notified the RN of the orders needed for catheter change. On 02/14/2025, LPN 1 observed macerated wound edges, noted a decline in wound status, and recorded Patient #6's right buttocks wound size as 1.7cm x 0.2 cm x 0.2 cm. LPN 1 had documented in the section titled, “Narrative Notes” changed Patient #6’s suprapubic catheter. The LPN used a 16 French catheter with a 10 cc balloon anchored per sterile technique without difficulty with immediate yellow urine return. The section titled “Visit Plan-Communication” indicated no one contacted as a result of this visit. The note failed to evidence the LPN notified the RN of the increased wound size, changes in wound status, and the	G0606		

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G0606	Continued from page 28 orders needed for catheter change. A review of the communication notes dated 12/25/2024 through 02/19/2025 failed to evidence LPN 1 coordinated care services with RN 4 regarding the changes in Patient #6's wound, or the orders needed for catheter changes. During an interview on 02/21/2025 at 11:35 AM, when asked about the agency policy regarding wound changes and patient changes in condition processes for LPN reporting, RN 4, the case manager for Patient #6, indicated LPN 1 should have reported the wound changes, and need for catheter changes to the RN. RN 4 indicated the RN and LPN should have documented changes and care coordination for Patient #6 in the communication notes. 410 IAC 17-12-2(g)	G0606		
G0608	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure patient clinical records included information about the services the patient received from other agencies and failed to ensure they coordinated care delivery to meet the patient's needs for 1 of 1 (Patient: #6) active patient records reviewed of patients receiving outside attendant care services. Findings Include: 1. A review of an agency policy reviewed April 2020, titled "COORDINATION OF SERVICES WITH OTHER PROVIDERS" indicated but was not limited to, " … To ensure the coordination of services provided by the organization and by other service providers … The Case Manager will be responsible for the coordination between service providers … " 2. During a home visit on 02/21/2025 at 10:30 AM, Patient #6 indicated Person 15, a personal care attendant from Entity 14, a personal care attendant care agency, assisted with shopping and housekeeping. RN 4, the case manager for Patient #6, confirmed the patient received personal care assistance.	G0608		

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G0608	Continued from page 29 A review of Patient #6's plan of care for the recertification period 12/24/2024 to 02/21/2025 failed to evidence the patient had received attendant care services from another agency. A review of the communication notes dated 12/24/2024 to 02/21/2025 failed to evidence Patient #6 received attendant care services from Entity 16 and coordination of care. During an interview on 02/21/2025 at 11:35 AM, when queried regarding the agency policy for coordinating care with other agencies and the documentation process, RN 4 and the Clinical Manager indicated coordination of care with other providers should have been documented in the communication notes. 410 IAC 17-14-1(a)(1)(F)	G0608		
G0726	Nursing services supervised by RN CFR(s): 484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure supervisory visits were completed for LPNs providing care in 1 of 1 active clinical records reviewed receiving LPN services. (Patient: #6) Findings Include: 1. A review of an agency policy reviewed February 2021, titled "CONTENTS OF CLINICAL RECORD" indicated but was not limited to, " … Documentation of supervision … " 2. A review of the clinical record for Patient #6 contained skilled visits notes dated 12/25/2024 through 02/19/2025 electronically signed and dated completed by LPN 1. The clinical record failed to evidence RN documentation of supervisory visits. 3. During a home visit observation at Patient #6's residence on 02/21/2025 at 10:30 AM, Patient #6 indicated to RN #4 it had been around Christmas since RN 4's last visit.	G0726		

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G0726	Continued from page 30 During an interview on 02/21/2025 at 11:35 AM, when asked regarding the agency's policy on LPN supervisory visit frequency, RN 4 indicated LPNs are to be supervised every 30 days. 410 IAC 17-14-1(a)(1)(J)	G0726		
G0946	Administrator appointed by governing body CFR(s): 484.105(b)(1)(i) Standard: Administrator. The administrator must: (i) Be appointed by and report to the governing body; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to evidence the Administrator reported to the Governing Body for 1 of 1 home health agency. 1. A review of a policy titled, 'Governing Body Policy No. 1-002.1' stated, "… The Governing Body will appoint a qualified administrator and establish procedures and of systematic communication between the two …" 2. A review of the organizational chart failed to demonstrate the Administrator reported directly to the Governing Body. 3. In an interview with Administrative Staff #1 on 02/21/2025 at 11:15 AM, they indicated the organizational chart would be changed to reflect Administrative Staff #1 reports directly to the governing body. 410 IAC 17-12-1(b)(1)	G0946		
G0984	In accordance with current clinical practice CFR(s): 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed	G0984		

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G0984	Continued from page 31 to develop a standard of practice or policy and procedures for wound care provided in 1 of 1 agency. Findings include: 1. A review of the table of contents to the agency policy and procedure manuals failed to evidence policy and/or procedures for wound care. 2. On 02/19/2025 at 11 AM, during an interview with the Administrator, they indicated they did not have a policy and procedure in place for wound care.	G0984		