STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K095	A. BUILDING B. WING	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER LOVE HOME SERVICES LLC	7895 BROADWAY STE L, MERRILLVILLE, IN, 46410

(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 in accordance with 42 CFR 484.102 by the Indiana Department of Health. Survey Dates: 2/11/2025 to 2/14/2025 Census: 2	E0000		
E0037	EP Training Program 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).	E0037	Correction for E0037 The Clinical Manager will have an emergency preparedness plan training and in-service on 3/7/2025 with the Alternate Clinical Manager, HHA's and SN's. The training will consist of reviewing all policy and procedures and demonstrate staff knowledge of emergency procedures and documented on the HHA/SN In-service training completion sheet and filed in the personnel charts. Prevention for E0037 The Administrator WillieAnn Parker, Clinical	2025-03-07

	*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the		ensure emergency preparedness training be conducted with all new and existing staff upon hire, annually and as needed if policy and procedures are updated and will be documented as part of the required HHA in-service training.	

	hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.			

	*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:			

	(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the agency failed to ensure emergency preparedness training was provided and documented every 2 years in 5 out of 5 personnel records reviewed with direct patient care (CM, Alternate CM, HHA 1, HHA 2, HHA 3). Findings include:			

	The emergency preparedness documentation provided by agency and the personnel record for CM, Alternate CM, HHA 1, HHA 2, and HHA 3 failed to evidence emergency preparedness training provided in the years 2022, 2023, and 2024. During an interview on 2/12/2025 beginning at 11:03 AM, a review of emergency preparedness training was conducted for the personnel records for CM, Alternate CM, HHA 1, HHA 2, and HHA 3. CM relayed emergency preparedness training had not been conducted with the reviewed personnel since prior to 2022.			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure survey of a Home Health provider. Survey Dates: 2/11/2025 to 2/14/2025	G0000		

	Unduplicated skilled admissions: 0 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. A partially Extended Survey was announced to the Administrator on 2/12/2025 at 12:25 PM. Abbreviations used in report: Home Health Aide [HHA], Clinical Manager [CM], Registered Nurse [RN], Plan of Care [POC], Start of Care [SOC], Skilled Nurse [SN], Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST), Masters social worker (MSW), Activities of daily living (ADL), Durable Medical Equipment (DME), Quality Assurance Performance Improvement (QAPI).			
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit	G0514	Correction for G0514 The Clinical Manager revised the intake referral form to indicate the difference from the actual referral form and the Intake form on 2/17/2025. The Intake form will be used to take info regarding patient for possible admission. The Intake Referral form is to be used for actual referrals and orders made to agency	2025-02-17

	must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview the agency failed to ensure an initial assessment was conducted within 48 hours of referral or the practitioner ordered start of care dated in 1 of 1 active clinical record reviewed of a bedbound patient (Patient #1). Findings include: 1.The clinical record for Patient #1 included an Intake Referral form dated 2/5/2024 for requested HHA services eight hours a day, Monday through Friday. The clinical record included a start of care dated 2/20/2024. The clinical record failed to evidence an initial assessment within 48 hours of referral, nor a physician ordered start of care date. During an interview on 2/12/2025 beginning at 11:03 AM, CM relayed services were started when Patient's benefits were active and did not provide documentation that the physician was aware of the delay. 410 IAC 17-14-1(a)(1)(A)		that will be admitted for services which will initiate an initial assessment to be made by SN within 48 hours of the actual referral/order. The clinical record for Patient #1 included an Intake Referral form which was actually the Intake form, not the referral form or actual order from the MD. Form 1-Intake Referral Form 2-Intake form Prevention for G0514The Clinical Manager will review and ensure Form 1- Intake Referral/Order will be used for admissions to agency which a SN provide the initial assessment within 48 hours of the referral date or within 48 hours of the patient's return home of the or the MD ordered SOC date. The Physician will be notified of the start of care. If any delays in the SOC, it will be documented, and the Physician will be notified of the delay and the reason. The Administrator, WillieAnn Parker will review all referral intakes to ensure initial assessment are performed within 48 hours of the referral or order.	

G0528	Health, psychosocial, functional, cognition 484.55(c)(1) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: (1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure the content of the comprehensive assessment accurately reflected the patient's health, psychosocial, functional, and cognitive status in 2 of 2 active clinical records reviewed (Patients #1, 2). Findings include: 1.The clinical record for Patient #1 included a comprehensive reassessment dated 12/11/2024 that indicated Patient had wounds and a wound vac (negative pressure wound therapy). The comprehensive reassessment failed to evidence the location, measurement, nor assessment of wounds and wound vac. During an interview on 2/12/2025 beginning at 11:03 AM, CM revealed the wound	G0528	Correction for G-0528 1. The Clinical Manager will re-instruct all SN who perform comprehensive assessments and re-assessments on documentation to include complete assessment of all wounds, including wound therapy (wound vac), location of wound and measurements despite being managed by other agencies. Prevention for G-0528 The Clinical Manager will ensure the complete assessments and re-assessments has been completed to include complete wound assessment including therapies, measurements and location of wounds be included in the plan of care despite being manage by secondary agency. Correction for G-0528 2. The Clinical Manager will re-instruct all SN who perform complete comprehensive assessments and re-assessments on documentation to include a complete pain assessment on all patients. Prevention for G-0528 The Clinical Manager will ensure the complete assessments and re-assessments has been completed with a pain assessment which will be included in the plan of care. The Administrator, WillieAnn Parker will review all assessments to ensure 100% completion.	2025-02-17

	on the comprehensive assessment because another agency was managing the wound. 2. The clinical record for Patient #2 included a start of care on 9/28/2024 and a comprehensive reassessment documented on 1/21/2025 that failed to evidence a pain assessment. During an interview on 2/12/2025 beginning at 11:03 AM, the administrator revealed a pain assessment should be a part of the comprehensive assessment. 410 IAC 17-14-1(a)(1)(B)			
G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on record review and interview, the agency failed to ensure the comprehensive assessment accurately reflected the patient's primary caregiver, available support, and their willingness, ability, availability,	G0538	Correction for G-0538 The Clinical Manager will re-instruct on 2/17/2025 all SN's when performing comprehensive assessments on patients who depend on others for care with caregivers to include any and all available support including their willingness and ability to provide care to be included in the plan of care. Prevention for G-0538 The Administrator, WillieAnn Parker and Clinical Manager will ensure the comprehensive assessment will have documentation which will be included in the plan of care regarding the caregiver's willingness, availability, work schedule and ability to care for patients who have primary	2025-02-17

	and schedules to provide care in 1 of 1 active clinical record with a home visit (Patient #1). Findings include: During a home visit observation on 2/12/2024 beginning at 7:28 AM, HHA 2 relayed the availability of Patient #1's caregiver, Other 1, was not often available on evenings and weekends. HHA 2 revealed Other 1 worked 24 hours shifts and Patient was often alone when HHA services were completed. The clinical record for Patient #1 included a comprehensive reassessment, dated 12/11/2024, which indicated Patient was dependent on others to complete ADL's and to get out of bed. The assessment included Patient's primary caregiver was Other 1, a family member, that was available on evenings and weekends, with notation Other 1 worked full time outside of the home. The clinical record failed to evidence an assessment of Other 1's schedule, availability, and ability to care for Patient.		caregivers.	
G0572	Plan of care	G0572	Correction for G0572	2025-02-17

	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. Based on record review and interview the agency failed to ensure each patient received the home health services that are written in the individualized plan of care that identifies patient-specific measurable outcomes and goals in 1 of 1 skilled active clinical record (Patients #2) and one of one closed clinical record of a patient with input and and output measurements ordered (Patient #6). Findings include: 1. The clinical record for Patient #2 included a POC dated 1/26/2025 to 3/26/2025 for SN visits every two weeks and HHA services three times a week, on Monday, Wednesday, and Friday, for nine weeks for 2 hours per visit. The clinical record included missed visits		1. The Clinical Manager will document and attempt to make up any visits missed by the HHA d/t holidays, patient MD appt etc. The Physican will be notified that the visit was missed, reason for missed visit and attempt to reschedule visit if applicable. Prevention for G-0572 The Clinical Manager revised the Missed Visit Order on 2/17/2025 to include reason of missed visit, date of rescheduled visit/ attempted rescheduled. The Clinical Manager will ensure to notify the Physician of any frequency change in writing if different from visit order initially on plan of care. The Clinical Manager will provide each patient a Holiday Schedule at the beginning of each year to be signed and returned to the office. Each patient will choose if they want a visit on a Holiday or not. The Clinical Manager will call the patient two weeks ahead of the scheduled holiday to see if patient was a visit or not. If a holiday visit is not wanted and interferes with the regular freq scheduled, the MD and patient will be notified ahead of time that the frequency is not being met. The visit will be attempted to be made up if applicable. A calendar will be provided at the beginning of each month and provided to the patient to include name of discipline, service to be provided, time of visit, any MD appts or Holidays that month. The MD will be notified if change of frequency r/t missed visit, reason for missed visit and attempt to make up visit with an order to be reviewed and signed. The Administrator, WillieAnn Parker will review, oversee and ensure all frequencies are met and inform MD and patient ahead of time to meet required needs of each patient. Correction for G-0572 2. The Clinical Manager will re-instruct SN to	

	dated 12/25/2024, 01/01/2025, and 2/20/2025 due to holidays. The clinical record failed to evidence the three HHA visits were made during the week of 12/25/2024, 1/1/2025, and 2/20/2025 nor were the agencies attempts to reschedule the services documented. During an interview on 2/12/2025 beginning at 11:03 AM, CM relayed the agency did not make attempts to make up the missed visits due to holidays. 2. The closed clinical record for Patient #6 included a POC dated 12/9/2021 to 2/6/2022 for SN services twice a week for one week then Monday through Friday for 3 hours per day for eight weeks to administer enteral (providing nutritional support directly into the gastrointestinal tract through a tube) nutrition, monitor vital signs, and monitor intake and output (measurement of fluids that enter and leave the body). The clinical record included SN visits documented on 2/4/2022, 2/1/2022, 1/31/2022,		perform services as indicated on plan of care and document intake and out-put on note to include on the plan of care. Prevention for G-0572 The Clinical Manager and the Administrator, Willie Ann Parker will ensure all plan of cares to include diagnosis, mental status, type of services, frequencies and duration of visits, prognosis, rehab potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures, patient risk for ER or Hosp re-admissions, pt and caregiver education and training and patient specific interventions and education with measurable goals.	

	1/26/2022, 1/25/2022, 1/24/2022, 1/21/2022, 1/20/2022, and 1/19/2022 that documented occurrence of diapers changed and failed to evidence documentation of fluid intake and fluid output by weighing diapers (1 gram weight equals 1 milliliter of fluid). The clinical record failed to evidence intake and output was recorded. During an interview on 2/14/2025 beginning at 8:40 AM, the CM revealed the intake and output was not recorded. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential;	G0574	Correction for G-05741. The Clinical Manager will re-instructed om 2/17/2025 all SNs when completing a comprehensive assessment to include all DME equipment be listed and documented on the plan of care, including wound vac, air mattress, Hoyer Lift etc. 2. The Clinical Manager will ensure all DME supplies are listed on the plan of care including foley catheter supplies, diabetic supplies, air mattress, hoyer lift and wound vac. The Clinical Manager will update all patient's medication list to include safety precautions if taking anti-platelet meds to include bleeding precautions. 3. The Clinical Manager will ensure and update	2025-02-17

	(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. Based on record review, observation, and interview the agency failed to ensure the individualized POC included patient's psychosocial status, types of services, supplies and equipment required, nutritional requirements, and safety measures to protect against injury in 2 of 2 active clinical records reviewed (Patients #1, 2) and 2 of 4 closed clinical records reviewed (Patients #5, 6). Findings include: 1.During a home visit observation on 2/12/2025 beginning at 7:28 AM, HHA 2 provided personal care for Patient #1. Patient was on a hospital bed with an electric air		patient's plan of care to include patient specific diet and/or nutritional requirement. 4. The Clinical Manager will ensure all patients on GI nutrition; the plan of care will provide the specific patient nutritional requirements and or feeding schedule including amount of flush as ordered by the Physican. Prevention for G-0574 The Clinical Manager will ensure all plan of cares to include diagnosis, mental status, type of services, frequencies and duration of visits, prognosis, rehab potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures, DME supplies, Patient risk for ER or Hosp re-admissions, pt and caregiver education and training and patient specific interventions and education with measurable goals. The Administrator, WiilieAnn Parker will review and oversee that all plan of cares include all pertinent information about the patient be listed before submitting to MD.	

	mechanical lift to transfer a person) was in the home. The clinical record for Patient #1 included a POC dated 12/16/2024 to 2/12/2025 for SN and HHA services. The comprehensive assessment dated 12/11/2024 indicated Patient had a wound vac (negative pressure wound therapy) managed by another agency. The POC failed to include the wound vac nor air mattress as DME required for Patient care. During an interview on 2/12/2025 beginning at 11:03 AM, CM relayed Patient had a wound vac and an air mattress at the time of the 12/11/2024 comprehensive assessment. She revealed the wound vac nor the air mattress were included in the DME list for Patient's 12/16/2024 to 2/12/2025 POC. 2. The clinical record for Patient #2 included a POC dated 1/26/2025 to 3/26/2025 for SN visits every two weeks and SN to change foley catheter (urinary catheter) every month. The DME and supplies list on the POC failed to evidence foley			

indicated Patient's medication list included Aspirin daily and the safety precautions on the POC failed to evidence bleeding precautions.

During an interview on 2/12/2025 beginning at 11:03 AM, the CM revealed the safety precautions should have included bleeding precautions due to Patient taking aspirin.

3. The closed clinical record for Patient #5 included a POC dated 5/24/2024 to 7/22/2024 for SN visits 1-2 times a month and HHA services four hours a day and seven days a week. The POC failed to evidence Patient's diet nor nutritional requirements.

During an interview on 2/14/2025 beginning at 8:40 AM, the CM relayed the Patient's nutritional requirements were not included in the POC.

4. The closed clinical record for Patient #6 included a POC dated 12/9/2021 to 2/6/2022 for SN services twice a week for one week then Monday through Friday for 3 hours per day for eight weeks to administer

	support directly into the gastrointestinal tract through a tube) nutrition and Patient nutritional requirements included nothing by mouth with Natural food blend 27 ounces daily per peg tube(surgically placed tube in stomach to provide nutrition that requires flushing to prevent blockages). The POC failed to evidence the feeding schedule for the 27 ounces of nutrition nor an ordered amount and type of flush for peg tube. 410 IAC 17-13-1(a)(1)(D)(ii, xiii, x)			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interviews, the agency failed to ensure services and treatments were administered only as ordered by a physician in 1 of 2 active clinical records reviewed (Patient #1). Findings include: The clinical record for Patient #2	G0580	Correction for G-0580 Clinical Manager phoned physician's office on 2/17/205 to send updated order with SN frequency and size of foley catheter on Patient #2. Prevention for G-0580 The Clinical Manager will ensure all orders from physician's office for foley catheter changes by SN will include the frequency and size of the urinary catheter and be performed as ordered. The Administrator, WillieAnn Parker will review all physician orders to ensure and confirm all information is included on the order before services are to be performed.	2025-02-17

	included a POC dated 1/26/2025 to 3/26/2025 for SN visits every two weeks and SN to change foley catheter (urinary catheter) every month. The clinical record included an order dated 11/26/2024 for SN to change foley catheter monthly and as needed. The SN visit note dated 01/06/2025 indicated foley catheter was changed, using an 18 French catheter. The physician order for a foley catheter procedure failed to evidence the size. During an interview on 2/12/2025 beginning at 11:03 AM, CM revealed the size of the urinary catheter was not included in the order. 410 IAC 17-13-1(a)			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observations and interviews, the agency failed to ensure accepted standards of practice to prevent the transmission	G0682	Correction for G-0682 The Clinical Manager notified HHA#2 of incorrect bag technique and infection control prevention upon completion of home visit on 2/12/025. The Clinical Manager had HHA#2 to come to the office and performed a skills performance demonstration on bag technique and disinfecting of equipment to prevent transmission of infection. Prevention for G-0682 Clinical Manager will we re-train and	2025-03-07

	of infections and diseases were followed in 1 of 1 active clinical record with a home visit (Patient #1). Findings include: During a home visit on 2/12/2025 beginning at 7:28 AM, HHA 2 provided care for Patient #1. HHA 2 washed her hands and reached in her supply bag and removed a thermometer and obtained a measurement on Patient. HHA 2 reached back into the supply bag and removed a blood pressure cuff, applied the cuff to Patient's wrist and started the automated blood pressure measurement. HHA 2 failed to evidence sanitizing hands prior to entering supply bag. After obtaining vital signs, HHA 2 used hand sanitizer liquid on paper towel to wipe the vital signs supplies and returned the items back into her bag.		document an In-service on infection control, including disinfecting medical equipment and bag technique with return demonstration including handwashing for all HHA's on 03/07/2025 to ensure prevention of transmission of infections and communicable diseases. The Administrator, WillieAnn Parker will oversee and ensure compliance is met with skills training of HHA's annually and as needed.	

	During an interview, on 2/14/2025 beginning at 8:40 AM, the Administrator relayed all staff were trained on the type of disinfectant product to use on their supplies, used in patients home, and using hand sanitizer on a paper towel was not sufficient. 410 IAC 17-12-1(m)			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interviews, the agency failed to ensure the RN assigned tasks appropriate to the HHA in 2 of 2 active clinical records reviewed (Patients #1, 2) and 1 of 3 closed clinical records with HHA services (Patient #5). Findings include: 1. The clinical record for Patient #1 included a POC dated	G0798	Correction for G-0798 1. The Clinical Manager reviewed clinical record for Patent #1 on 2/17/2025 and updated HHA POC to include task the patient requires assistance with mouth/oral hygiene and meal prep including safety precautions and diet. 2. The Clinical Manager reviewed the clinical record for Patient #2 on 2/17/2025 and update the HHA plan of care to include specific diet and safety precautions and will review with the HHA and the SN who performs complete comprehensive assessments to make sure the HHA plan of care regarding task to be completed match. 3. The Clinical Manager reviewed the closed clinical record for Patient #5 on 2/17/2025 and noted the HHA assignment sheet did not include safety measures. Prevention for G-0798 The Clinical Manager and the Administrator, WillieAnn Parker on 2/17/2025, revised the HHA plan of care to include safety precautions,	2025-02-17

	12/16/2024 to 2/13/2025 for SN services once to twice a month and HHA services Monday through Friday for 8 hours per day and indicated Patient safety measures included bleeding precautions. The record included a comprehensive reassessment dated 12/11/2024 indicating Patient needed assistance for oral hygiene. The HHA POC, last reviewed for updated on 12/20/2024 by CM, indicated HHA to provided mouth or denture care when Patient requested, to prep meals, and to serve meals. The HHA POC failed to evidence Patient's diet as ordered by a physician nor safety measures. During an interview on 2/12/2025 beginning at 11:03, the CM revealed Patient was able to do oral care and required assistance to complete the task. CM relayed oral care was not a task included in the HHA POC nor were safety precaution and Patient's diet included in the HHA POC. 2. The clinical record for Patient #2 included a POC dated 1/26/2025 to 3/26/2025 for SN visits every two weeks and HHA visits Monday, Wednesday, and		diet, functional limitations and activities permitted including infection control, fall prevention which will be reviewed every 60 days and/or if patient condition changes with the HHA and Patient.	

	Friday for 2 hours per day. The POC revealed Patient safety measure included: fall precautions and seizure (convulsions) precautions and Patient's was prescribed a diabetic diet. The clinical record included an HHA POC, last reviewed on 1/22/2025 by CM, revealed HHA tasks to include prepare meals and serve meals. The HHA POC failed to evidence safety precautions nor Patient's diet. The clinical record included a comprehensive reassessment dated 1/21/2025 and documented by CM that indicated Patient was able to bathe in the shower or tub only with the assistance of another person. The HHA POC included the task "assist at sink" and failed to evidence the task of assistance with a shower or tub bath. During an interview on 2/12/2025 beginning at 11:03 AM, the CM relayed Patient needs assistance to bathe and the task to "assist at sink" was to assist Patient to "wash up". 3. The closed clinical record for Patient #5 included a POC			

	dated 5/24/2024 to 7/22/2024 for SN visits 1-2 times a month and HHA services four hours a day and seven days a week. The POC included safety measures including clear paths, infections control measures, fall prevention, and require assistance to ambulate safely. The HHA assignment sheet failed to include Patient safety measures. During an interview on 2/14/2025 beginning at 8:40 AM, the CM revealed Patient safety measures were not included on the HHA POC. 410 IAC 17-14-1(m)			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review and interviews, the agency failed to ensure the HHA provided services	G0800	Correction for G-0800 The Clinical Manager reviewed the clinical record for Patient #1 on 2/17/2025 who requires a Hoyer Lift. The HHA demonstrated use of Hoyer in home with RN supervision. Preventions for G-0800 The Clinical Manager will document and provide training to all HHA's who assist patients with transfers using a Hoyer Lift or other devices with in-home demonstration under Clinical Manager or Alternate Clinical Manager supervision for safety.	2025-02-17

	consistent with HHA training in 1 of 1 active clinical record of a patient that requires a mechanical lift to move patient (Patient #1). Findings include: The clinical record for Patient #1 included a POC dated 12/16/2024 to 2/13/2025 for SN services once to twice a month for two months and HHA services eight hours a day, Monday through Friday each week. The POC indicated a Hoyer life (mechanical lift using a sling to transfer a patient) was required to transfer or transport Patient. HHA visits were documented and dated January 13, 15, 17, 22, 24, 27, 29, and 31, of 2025 by HHA 2 which indicated Patient was assisted with a transfer out of bed and assisted with transfer back to bed. The personnel record for HHA 2 included a hire date of 5/24/2013 and failed to evidence Hoyer lift nor mechanical lift training. During an interview on 2/14/2025 beginning at 8:40 AM, CM relayed there was not documentation that HHA was trained to use a mechanical lift		Administrator, WillieAnn Parker will ensure all training be provided upon hire and a skills performance will be performed annually and as needed if HHA needs additional training by Clinical Manager or Alternate Clinical Manager.	

	to move a patient.			
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: 02/11/2025 to 02/14/2025 Unduplicated skilled admissions: 0	N0000		
N0447	Home health agency administration/management 410 IAC 17-12-1(c)(4) Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities.	N0447	Correction for N0447 The Clinical Manager removed the document titled "Scope of Services" that indicated the agency provides SN, PT and HHA services on 2/17/2025. An updated document was revised indicating SN and HHA services are provided at this time and placed in the agency admission folder indicating the agency provides SN and HHA services. Prevention for N0447 The Administrator, Wilie Ann Parker and Clinical Manager will ensure that only services provided by the agency will be placed in the admission folder.	2025-02-17

	Based on record review and interviews, the agency failed to ensure the accuracy of public information materials and activities. Findings include: The agency admission folder included a documented titled "Scope of Services" that indicated the agency provides SN, PT, and HHA services. During the entrance conference on 2/11/2025 beginning at 9:44 AM, the Administrator relayed the agency provides SN and HHA services and does not provide PT services. In a subsequent interview on 2/12/2025 beginning at 11:03 AM, the Administrator revealed the agency provided PT services years ago and no longer provided PT services.		The Administrator WillieAnn Parker and Clinical Manager after completion of the survey, it was discussed requesting the agency to be deemed for Medicare clients to include PT, OT, Infusion Therapy and other Medicare services.	
N0458	Home health agency administration/management 410 IAC 17-12-1(f) 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	N0458	Correction for N0458 1. The Clinical Manager called the Alternate Clinical Manager in the office on 2/14/2025. The job description for Alternate Clinical Manager was signed, dated by the Alternate Clinical Manager and was filed in the personnel file on 2/14/2025 by the Clinical Manager. Prevention for N0458	2025-02-14

	services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of an employee's national/expanded criminal history background check pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the agency failed to ensure the personnel records of employees who deliver home health services were kept current including a receipt of their job description and annual performance evaluations in 2 of 2 CM personnel files reviewed (CM nd Alternate CM). Findings include: 1.The personnel file review for Alternate CM included a job description as an RN and failed to include a job description receipt as Alternate CM. During an interview on		The Administrator, WillieAnn Parker and Clinical Manager will ensure all job descriptions are assigned and will be placed in the personnel file of all employees including anyone who obtains a new job title or description as soon as the job description changes or is designated. Correction for N0458 2. On 2/14/2025, The annual performance evaluation review for the Clinical Manager was performed, documented, dated and signed by the Administrator WillieAnn Parker and was included in the Clinical Manager personnel file for May 2024. Prevention for N0458 The Administrator, WillieAnn Parker will perform and document an annual performance evaluation review for the Clinical Manager, yearly and promptly file in the personnel file. The Clinical Manager will remind and ensure compliance of the Administrator completing an annual performance review when due.	

	2/12/2025 beginning at 11:03 AM, the CM relayed the personnel file for Alternate CM did not include a job description for Alternate CM. 2. The personnel file review for CM failed to evidence an annual performance evaluation since the last evaluation dated May of 2023. During an interview on 02/12/2025 beginning at 11:03 AM, the Administrator relayed there was no documentation of the CM's annual performance evaluation.			
N9999	Final Observations Authority IC 16-27-1.5-5 "Approved dementia training for home health aides" Sec. 5 (a) This section applies to a registered home health aide who: (1) is employed as a home health aide; and (2) provides care to an individual who has been diagnosed with or experiences symptoms of Alzheimer's disease, dementia, or a related cognitive disorder. (b) As used in this section, "approved dementia training" refers to a dementia training program: (1) for use in training home health aides in the care of individuals described in subsection (a)(2); and (2) that has been approved by the state department under subsection (f).	N9999	Correction for N-9999 The Administrator, WillieAnn Parker phoned IAHHCC to inquire information regarding membership. Membership will be obtained 3/17/2025. Upon acceptance, Clinical Manager will implement and train all HHA"s on State Approved Dementia Training as required no later than 03/21/2025. Prevention for N-9999 The Clinical Manager will provide, and document state approved dementia training obtained by IAHHCC to all HHA's upon hire and in-service training yearly and as needed as part of the minimal requirements for HHA training. The Administrator, WillieAnn Parker will ensure all HHA's in-service requirements are state approved and provided yearly as required.	2025-03-07

(c) Not later than sixty (60) days after the date on which a home health aide is initially hired to care for an individual with Alzheimer's disease, dementia, or a related cognitive disorder, the home health aide shall complete at least six (6) hours of approved dementia training.

(d) Before December 31 of each year, a home health aide who has been employed as a home health aide for at least one (1) year shall complete at least three (3) hours of approved dementia training.

(e) A home health aide who:

(1) has received the training required by subsections (c) and (d);

(2) has been employed as a home health aide for at least twenty-four (24) consecutive months; and

(3) is hired by a home health agency; is not required to repeat the training required by this section.

(f) The state department shall do the following:

(1) Identify and approve each dementia training program that meets the following requirements:

(A) The dementia training program includes education concerning the following:

(i) The nature of Alzheimer's disease, dementia, and other related cognitive disorders.

(ii) Current best practices for caring for and treating individuals with dementia.

(iii) Guidelines for the assessment and care of an individual with dementia.

(iv) Procedures for providing patient centered quality care.

(v) The daily activities of individuals with dementia.

(vi) Dementia related behaviors, communication, and positive intervention.

(vii) The role of an individual's family in caring for an individual with dementia.

(B) The dementia training program:

(i) must be culturally competent; and

(ii) may be provided online.

(2) Establish and implement a process for state department approval of a dementia training program.

(g) To the extent allowed by 42 CFR 484.80, the hours of approved dementia training completed under this section satisfies an equivalent number of hours of the home health aide training required by 42 CFR 484.80.

(h) An entity that provides approved dementia training shall provide to each home health 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

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 record review and interviews the agency failed to ensure that approved dementia training was provided to HHA who provided care to an individual diagnosed with dementia or a related cognitive disorder in 1 of 1 clinical record reviewed with a diagnosis of dementia (Patient #3).

Findings include:

	The closed clinical record for Patient #3 included a POC dated 9/20/2024 to 11/18/2024 that indicated Patient's primary diagnosis was dementia and HHA visits were provided. HHA 1 documented their aide visits, dated 10/31/2024, 10/17/2024, 11/7/2024, 10/10/2024, 9/19/2024, 9/12/2024, 9/5/2024, 8/29/2024, 8/22/2024, and 9/15/2024. The personnel record for HHA 1 included a hire date of 4/7/2016 and failed to evidence they completed approved dementia training. During an interview on 2/12/2025 beginning at 11:03 AM, the CM relayed the agency dementia training included watching a public dementia video with a written test after the video. The CM was unaware if the training was approved and did not provide evidence their dementia training was approved nor that it meant the minimum requirement(s).			

WillieAnn Parker	Administrator	3/18/2025 5:24:39 PM