STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157554	A. BUILDING B. WING	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	2509 W 2ND STREET, MARION, IN, 46952

(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: March 5, 6, 10, 12, 13, 14, and 17, 2025 Active Census: 398 At this Emergency Preparedness survey, Angels of Mercy Homecare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. Abbreviations: EP Emergency Preparedness	E0000		
G0000	INITIAL COMMENTS	G0000		

	This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: March 5, 6, 10, 12, 13, 14, and 17, 2025 12-Month Unduplicated Skilled Admissions: 1158 The survey was partially extended on 03/12/2025 at 9:40 AM. The survey was extended on 03/13/2025 at 4:20 PM. During this Federal Recertification Survey, Angels of Mercy Homecare was found to be out of compliance with Condition of Participation 484.60 Care planning, coordination of services, and quality of care. Based on the Condition-level deficiencies during the 03/17/2025 survey, your HHA was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 03/13/2025. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating a home health			

	aide training, skills competency and/or competency evaluation programs for a period of two years beginning 03/17/2025 and continuing through 03/16/2027. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Abbreviations: SN Skilled Nurse RN Registered Nurse PT Physical Therapist PTA Physical Therapist Assistant OT Occupational Therapist COTA Certified Occupational Therapy Assistant ADLs Activities of Daily Living SOC Start of Care LPN Licensed Practical Nurse HHA Home Health Aide CM Clinical Manager			
G0520	5 calendar days after start of care 484.55(b)(1)	G0520	Immediate action implemented to correct specificdeficiency:	2025-04-16

	The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on record review and interview, the home health agency failed to ensure all therapy evaluations were conducted within five calendar days after the SOC for 4 of 8 active records reviewed of patients with physical therapy and/or occupational therapy services ordered (Patients #1, 5, 9, 12). Findings include: 1. The agency policy "Patient Assessment, Initial and Reassessment," revised 9/01/24, indicated the PT and OT would make initial evaluations to determine the need for specific therapies. The evaluations were to be conducted within five days of the SOC or ordered date. 2. The review of Patient #1's clinical record indicated Patient was referred to the agency for physical therapy and occupational therapy services. Patient's SOC date was 2/17/25. A PT comprehensive assessment visit, documented on 2/17/25 by PT 2, indicated Patient requested SN and occupational		Occurrence report was entered for patient's # 1, 5, 9,and 12 due to failure to complete timely therapy evaluation. Patient # 12 declined Occupational Therapy evaluationand physician was notified. 100% of active census to be reviewed to ensure alltherapy evaluations were completed by 3/28/25. Physician will be notified ofany issues of non-compliance and occurrence report to be entered. Contract Physical and Occupational Therapy staff havebeen added to provider. During a mandatory team meeting held on 4/2/25 and4/3/25, the Executive Director (ED) instructed all staff on ensuring alltherapy evaluations are conducted within 5 calendar days of the	

	therapy services during the admission visit. A POC for the initial certification period of 2/17/25 – 4/17/25 included orders for an OT evaluation, effective 3/02/25. The record failed to evidence Patient was notified and in agreement with the delayed OT evaluation. The record included an order, dated 2/19/25, for SN evaluation to be completed the week of 2/23/25 – 3/01/25. The record failed to evidence Patient was notified and in agreement with the delayed SN evaluation. A SN evaluation was documented on 2/26/25 by RN 4, which was nine days after Patient had requested services and seven days after an order was obtained. During an interview on 3/13/25 beginning at 2:51 PM, RN 4 reported she was unsure the reason Patient's nursing evaluation was completed nine days after SOC. An OT evaluation was documented on 3/04/25 by OT		Start of Care (SOC),Resumption of Care (ROC), or order referencing Policy # 2.1.002 PatientAssessment, Initial and Reassessment. For any staff unable to attend the mandatory training,1:1 remediation will be provided by the ED or Clinical Director (CD) prior to resumingpatient care. New process that will be implemented to preventdeficiency from re-occurring: Physical Therapist, Speech Therapist, OccupationalTherapist, Medical Social Worker, and Dietitian may make initial evaluations ofthe patient status to determine the need for specific therapies. Thisinitial discipline specific evaluation(s) will occur within 5 days from theStart of care (SOC) date or order date or sooner if medically necessary.	

	Patient had requested services and the POC was initiated. During an interview on 3/13/25 beginning at 1:20 PM, OT 1 reported an OT evaluation was to be completed within 24-48 hours of being ordered. OT 1 was unsure the reason Patient's OT evaluation was conducted 15 days after SOC, but reported she was the only OT assigned to the branch, and had limited availability. During an interview on 3/17/25 beginning at 10:42 AM, Patient Care Manager 3 reported the agency had 5 – 7 days to conduct evaluation visits after the SOC. The nurse reported after Patient requested SN and occupational therapies at SOC, Patient Care Manager 3 had written the order for SN to start the following week, since the order was obtained on a Wednesday. Patient Care Manager 3 reported the OT evaluation was ordered for the week of 3/02/25 due to staffing availability. The nurse reported the delay in evaluations should have been discussed with Patient during the SOC visit. During an interview on 3/17/25		A" Do Not Move" Buddy Code will be added to theschedule along with the scheduled evaluation visit to alert the clinician thatthis visit cannot be moved to another date. In event the patient requests to delay the initialtherapy evaluation, the request will be documented in the medical record andthe physician will be notified. Scheduler will runthe Home Care Home Base (HCHB) Scheduling Report daily to ensure all orderedvisits have been scheduled. BusinessManager (BM) verifying daily. Title of person responsible for implementing plan of correction: Executive Director Monitoring procedures to ensure effectiveness ofprocess	

	beginning at 12:15 PM, PT 2 reported during the SOC visit, he did not discuss the timeframe Patient's SN and occupational therapy services were to begin, as he was unsure when orders would be obtained and when the staff would be available. 3. The review of Patient #5's clinical record indicated Patient was referred to the agency for physical therapy and occupational therapy services. Patient's SOC date was 2/10/25. A POC for the initial certification period of 2/10/25 – 4/10/25 included orders for an OT evaluation, effective 2/16/25. The record failed to evidence Patient was notified and in agreement with the delayed OT evaluation. An OT evaluation was documented on 2/17/25 by OT 3, which was seven days after the SOC. During an interview on 3/14/25 beginning at 2:15 PM, Patient Care Manager 5 reported a therapy evaluation was to be completed within five days of the SOC. The nurse reported Patient's record failed to		compliance: Beginning 4/17/25, the ED, Clinical Director (CD),and/or Patient Care manager (PCM) will review 100% of SOC and ROC to ensureinitial therapy evaluations are completed within 5 days of SOC, ROC, orphysician order. Monitoring will continue for 3 consecutive weeks anduntil 100% compliant for 2 consecutive weeks. Once compliance is achieved, the ED, CD, and/or PCMwill review 50% of SOC and ROC to ensure initial therapy evaluations arecompleted within 5 days of SOC, ROC, or physician order. Monitoring will continue for 8 consecutive weeks anduntil 100% compliant for 4 consecutive weeks.	

	evidence the reason Patient's OT evaluation was delayed. 4. The review of Patient #9's clinical record indicated Patient was referred to the agency for skilled nursing, physical therapy, and home health aide services. Patient's SOC date was 1/31/25. A POC for the initial certification period of 1/31/25 – 3/31/25 indicated a PT evaluation was to be completed, effective 2/02/25 and an OT evaluation was to be completed, effective 02/09/25. The record failed to evidence Patient was notified and in agreement with the delayed PT and OT evaluations. A PT evaluation was documented on 2/07/25 by PT 2, which was seven days after Patient's SOC. The record included orders to reschedule Patient's OT evaluation on 2/11/25 and 3/04/25 by Patient Care Manager 3. The record failed to evidence the reason for the rescheduled visits and failed to evidence Patient was aware and in agreement with the rescheduled visits. The review of the record on		The ED will report monitoring results to the QualityAssessment Performance Improvement (QAPI) Team quarterly until goals areachieved.	

	3/12/25 failed to evidence an OT evaluation had been completed. During an interview on 3/13/25 beginning at 12:56 PM, Patient reported he/she had needed assistance with ADLs after being discharged from the hospital, but he/she did not have any assistance, so Patient "learned to do it myself." Patient reported they had an OT evaluation that morning, which was the first time he/she had heard from the agency regarding the OT evaluation. During an interview on 3/17/25 beginning at 8:32 AM, COTA 2 reported she had provided home health aide services to Patient. The OT assistant reported Patient did have a need for OT services, as Patient had decreased range of motion and needed assistance with ADLs. COTA 2 stated she thought OT 1 was going to conduct an OT evaluation visit, but was unsure of the reason the evaluation had not been done. During an interview on 3/13/25 beginning at 1:20 PM, OT 1 reported she had not been			

assigned an OT evaluation for Patient.

During an interview on 3/13/25 beginning at 3:32 PM, Alternate Clinical Manager reported during Patient's SOC visit, the nurse had explained the agency only had one OT working limited hours, so the OT service start could be delayed. The nurse was unable to provide documentation of patient notification and agreement for the delay in OT services.

During an interview on 3/17/25 beginning at 10:51 AM, Alternate CM reported the agency had conducted the PT evaluation seven days after the SOC due to Patient request. Alternate CM was unable to provide documentation of this request.

During an interview on 3/13/25 beginning at 3:56 PM, Patient Care Manager 3 reported Patient had requested to reschedule the OT evaluation on 2/11/25 and 3/04/25. Patient Care Manager 3 was unable to provide documentation of these requests.

5. The review of Patient #12's clinical record indicated Patient

	was referred to the agency on 1/23/25 for SN, physical therapy, and occupational therapy services. Patient's SOC date was 1/29/25. A POC for the initial certification period of 1/29/25 – 3/29/25 included orders for a PT evaluation and OT evaluation, effective 2/02/25. The record failed to evidence Patient was notified and in agreement with the delayed PT and OT evaluation. A PT evaluation was documented on 2/06/25 by PT 2, which was eight days after the SOC. During an interview on 3/17/25 beginning at 12:18 PM, PT 2 reported he was unsure the reason Patient's PT evaluation was conducted eight days after the SOC.			

	The record included orders to reschedule Patient's OT evaluation on 2/04/25 and 2/11/25 by Patient Care Manager 3. The record failed to evidence the reason for the rescheduled visits and failed to evidence Patient was aware and in agreement with the rescheduled visits. The review of the record on 3/13/25 failed to evidence an OT evaluation had been completed. During an interview on 3/17/25 beginning at 10:51 AM, Alternate CM reported she was unsure the reason Patient's PT evaluation was conducted eight days after the SOC. Alternate CM reported Patient's OT evaluation had been rescheduled due to staff availability. The nurse reported she had attempted to discuss the rescheduling with Patient via phone, but Patient did not answer the agency's calls. Alternate CM was unable to provide documentation of these attempts.			

G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the home health agency failed to ensure a discharge summary was sent to the patient's physician for 1 of 5 discharge patient records reviewed (Patient #14). Findings include: 1. The Patient Discharge/ Transfer Process policy, revised 10/01/2023, indicated "...A discharge summary... is sent to the physician or other healthcare professional responsible for care after discharge from the agency within 5 business days of patient's discharge..." 2. Review of Patient #14's record failed to include a discharge summary was sent to the patient's physician. 3. During an interview on	G0564	Immediate action implemented to correct specificdeficiency: Occurrence report was entered for patient # 14 due tofailure to submit a discharge summary to the physician. During a mandatory team meeting held on 4/2/25 and4/3/25, the Executive Director (ED) instructed all staff on ensuring adischarge summary is sent to the physician within 5 business days of dischargereferencing Policy # 2.1.004 Patient Discharge/Transfer Process. For any staff unable to attend the mandatory training,1:1 remediation will be provided by the ED or Clinical Director (CD) prior toresuming patient care. New process that will be implemented to preventdeficiency from re-occurring:	2025-04-16

	03/17/2025 at 1:24 PM, the Administrator indicated documentation the discharge summary was sent to the physician should be in the communication notes. The Administrator further indicated she would attempt to locate documentation that a discharge summary for Patient #14 was sent to the physician. 4. During an interview on 03/17/2025 at 2:40 PM, the Administrator indicated she couldn't find that a discharge summary was sent to Patient #14's physician. 410 IAC 17-14-1(a)(1)(B)		A discharge summary including admission and dischargedates, reason for admission to home health, reason for discharge, servicesprovided to the patient, patient's condition at time of discharge, a briefsummary of care provided, progress towards goals, patient's discharge goals ofcare, patient's treatment preferences, a list of community resources or referrals made, along with a current medication listis sent to the physician or other healthcare professional responsible for care afterdischarge from the agency within 5 business days of patient's discharge. Office Assistant (OA) sends the completed dischargesummary to the physician. The Business Manager (BM) will review dischargesweekly and ensure the discharge summaries were successfully sent to thephysician,	

			Title of person responsible for implementing plan ofcorrection: Executive Director Monitoring procedures to ensure effectiveness ofprocess improvement and continued compliance: Beginning 4/17/25, the ED, Clinical Director (CD),Patient Care Manager (PCM), or BM will review 100% of discharges to ensure adischarge summary was sent to the physician within 5 business days ofdischarge. Monitoring will continue for 3 consecutive weeks anduntil 100% compliant for 2 consecutive weeks. Once compliance is achieved, the ED, CD, PCM, or BM willreview 50% of discharges to ensure a discharge summary was sent to thephysician within	

			5 business days of discharge. Monitoring will continue for 8 consecutive weeks anduntil 100% compliant for 4 consecutive weeks. Any discharge summaries that were found to be unsent,will be immediately sent to the physician and employee disciplinary action willoccur. The ED will report monitoring results to the QualityAssessment Performance Improvement (QAPI) Team quarterly until goals areachieved	
G0570	Care planning, coordination, quality of care 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	G0570	Immediate action implemented to correct specificdeficiency: Occurrence report was entered for patient’s # 3, 9, 11,and 13 due to failure to complete timely therapy evaluation.	2025-04-16

	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. Based on observation, record review, and interview, the home health agency failed to ensure the POC included an accurate medication list (see Tag G574), failed to ensure wound care was performed according to the current physician order (see G580), failed to notify the physician of changes in the patient's arm circumference measurement and failed to notify the physician of an increase in wound measurements (see G590). Based on observation, record review, and interview, the home health agency failed to meet the rehabilitative needs of the patient for 4 of 10 records reviewed of patients with ordered physical and/or occupational therapy services ordered (Patients #3, 9, 11, 13). The cumulative effect of these systemic issues evidenced the agency failed to meet all patients' needs, which resulted in Angels of Mercy Homecare being found out of compliance with 42 CFR		Occupational Therapy evaluation was completed forpatient # 3. Patient # 13 was previously discharged from homehealth services. 100% of active census to be reviewed to ensure alltherapy evaluations were completed. Review to be completed by 3/28/25. Physicianwill be notified of any issues of non-compliance and occurrence report to beentered. Contract Physical and Occupational Therapy staff havebeen added to provider. During a mandatory team meeting held on 4/2/25 and4/3/25, the Executive Director (ED) instructed all staff on admission criteriawith emphasis on ensuring the provider has available staff to meet theimmediate and	

	Condition for Participation 484.60 Care planning, coordination of care, and quality of care. Findings include: 1. The review of agency policy "Acceptance of Patients/Admission Process," last revised 1/01/25, indicated admission criteria included the agency "must be able to meet the patient's needs including staffing of available services adequate to meet the immediate and ongoing patient care needs in appropriate timeframes …." 2. The review of Patient #3's clinical record indicated Patient was referred to the agency on 11/26/24 for physical therapy due to "frequent falls, generalized weakness, very sedentary." The referral order indicated Patient's primary caregiver was "struggling to help" Patient with his/her care, "primarily bathing," and was "interested in home help available." The referring provider noted Patient had diffuse left arm pain, which was Patient's dominant side. Patient began receiving home physical therapy services on 12/03/24.		ongoing patient care needs in appropriate timeframes referencingPolicy # 2.1.001 Acceptance of Patients/Admission Process. During a mandatory team meeting held on 4/2/25 and4/3/25, the Executive Director (ED) instructed all staff on ensuring alltherapy evaluations are conducted within 5 calendar days of the Start of Care(SOC) or order referencing Policy # 2.1.002 Patient Assessment, Initial andReassessment. For any staff unable to attend the mandatory training,1:1 remediation will be provided by the ED or Clinical Director (CD) prior toresuming patient care. New process that will be implemented to preventdeficiency from re-occurring: Patients admitted to home care services must have	

	A PT visit note, documented by PTA 4 on 1/07/25, evidenced Patient reported they could not raise their left arm. Patient felt their shoulder was getting weaker, and he/she reported being unable to comb their hair due to shoulder weakness. An order was obtained on 1/07/25 by Patient Care Manager 3 for an OT evaluation due to left shoulder pain. An OT evaluation note, documented on 1/18/25 by OT 1, evidenced Patient reported "significant" pain to the left neck and shoulder, "affecting safety with ADL [activities of daily living] completion." Patient required maximum assistance with all ADLs. OT 1 documented Patient would benefit from occupational therapy services to "increase strength and endurance as well as reduce pain in left shoulder to allow Patient to regain greater functional ADL independence." An order for OT services was obtained, with OT visits occurring once per week for one week, twice per week for one week, then once per week for one week.		reasonableexpectations that needs can be met safely in the home. The agency must be able to meet the patient's needsincluding staffing of available services that are required to meet theimmediate and ongoing patient care needs in appropriate timeframes. Referrals will not be accepted for those patientswhose care needs cannot be met due to lack of available resources. ED willreview all referrals to ensure adequate resources available to meet patientcare needs. Physical Therapist, Speech Therapist, OccupationalTherapist, Medical Social Worker, and Dietitian may make initial evaluations ofthe patient status to determine the need for specific therapies. Thisinitial discipline specific evaluation(s) will occur within 5 days from theStart of care (SOC) date or order date or	

	An OT visit note, documented on 1/29/25 by COTA 2, evidenced Patient reported pain to the left shoulder, which worsened with movement. Patient required maximum assistance with ADLs including oral care and donning socks. COTA 2 documented Patient's therapy plan was to "continue occupational therapy to address pain, strengthening and endurance." A COTA case conference between OT 1 and COTA 2, documented on 1/31/25, evidenced COTA 2 was to continue with Patient's treatment plan. A POC for the recertification period of 2/01/25 – 4/01/25 indicated Patient was to receive an OT re-evaluation, effective 2/09/25. The record included orders to reschedule Patient's OT re-evaluation, obtained on 2/06/25, 2/10/25 and 3/06/25 by Patient Care Manager 3 and Alternate Clinical Manager. The record failed to evidence the reason for the rescheduled visits and failed to evidence Patient was aware and in agreement		sooner if medically necessary. A" Do Not Move" Buddy Code will be added to theschedule along with the scheduled evaluation visit to alert the clinician thatthis visit cannot be moved to another date. Upon SOC, Resumption of Care (ROC), Recertification,or during the episode of care, if the need for additional therapy disciplines isidentified, the physician will be contacted, and updated orders obtained. ThePatient Care Manager (PCM) will maintain a list of add-on evaluations requiredand track for receipt of orders. In event the patient requests to delay the initialtherapy evaluation, the request will be documented in the medical record andthe physician will be notified. Schedulers will run the Scheduling Request andAuthorizations Report twice	

	with the rescheduled visits. The review of the record on 3/06/25 failed to evidence an OT re-evaluation had been completed. During a home visit observation with Patient #3 on 3/06/25 beginning at 2:38 PM, Patient reported pain to the left shoulder and was unable to lift his/her left arm past his/her chest. Patient also reported difficulty with writing. Patient asked PT 2 if occupational therapy was going to provide any further services, to which PT 2 responded he had put a request in for an OT evaluation. During an interview on 3/06/25 beginning at 3:28 PM, Patient #3 reported they had previously received OT services, and was told by agency staff the services were to continue, however no OT had attempted to schedule a visit in over one month. Patient reported they had not spoken with anyone at the agency about a change in OT services. During an interview on 3/13/25 beginning at 1:20 PM, OT 1 reported when a patient's ordered OT services were to		daily to identify visits that are in requested orunscheduled status to ensure all add-on evaluations are completed. Business Manager (BM) will verify this report has beenrun and necessary scheduling adjustments completed to ensure all add onevaluations are scheduled within 5 days of order. Title of person responsible for implementing plan ofcorrection: Executive Director Monitoring procedures to ensure effectiveness ofprocess improvement and continued compliance: Beginning 4/17/25, the ED, Clinical Director (CD),and/or PCM will review 100% of SOC, ROC,and Recertifications to ensure initial therapy evaluations are completed within5 days of SOC, ROC, or	

	patient needed a re-evaluation or services were to end based on the case conference with COTA 2. If COTA 2 reported a patient had not yet met their goals, the OT would obtain an order to re-evaluate the patient. When asked the reason Patient's OT services did not continue after 1/29/25, OT 1 reported Patient's certification period had ended on 2/01/25, and she thought COTA 2 had reported Patient was progressing towards their goals. When asked the reason Patient's re-evaluation had been rescheduled three times, OT 1 reported this was done by the agency office staff due to the OT's limited availability. The OT reported she did not communicate with Patient regarding rescheduling the evaluation. During an interview on 3/17/25 beginning at 8:28 AM, COTA 2 reported the plan for Patient at the time of recertification was to continue OT services. COTA 2 reported there was a "gap" in services due to staffing availability. During an interview on 3/13/25 beginning at 3:32 PM, Alternate		physician order. Monitoring will continue for 3 consecutive weeks anduntil 100% compliant for 2 consecutive weeks. Once compliance is achieved, the ED, CD, and/or PCMwill review 50% of SOC, ROC, and Recertifications to ensure initial therapyevaluations are completed within 5 days of SOC, ROC, or physician order. Monitoring will continue for 8 consecutive weeks anduntil 100% compliant for 4 consecutive weeks. The ED will report monitoring results to the QualityAssessment Performance Improvement (QAPI) Team quarterly until goals areachieved. If any deficient findings are noted, the physicianwill be	

	Clinical Manager reported the agency had to reschedule Patient's OT re-evaluation for the weeks beginning 2/10/25 and 3/06/25 due to staff availability. Alternate Clinical Manager reported she did not document her communication with Patient regarding the schedule changes. During an interview on 3/13/25 beginning at 3:46 PM, Patient Care Manager 3 reported the agency had to reschedule Patient's OT re-evaluation for the week beginning 2/06/25 due to staff availability. Patient Care Manager reported she did not document her communication with Patient regarding the schedule changes. 3. The review of Patient #9's clinical record indicated Patient was referred to the agency on 1/23/25 for SN, HHA, and physical therapy services. Patient's primary diagnosis was fracture of the left forearm. Referral documents included an inpatient OT evaluation, which evidenced Patient had deficits with ADLs and IADLs, including "bathing/showering, Toileting/hygiene, Dressing,		notified and orders obtained and visits scheduled to immediatelyinitiate the service (s). For instances of non-compliance, the ED will provide1:1 remediation up to and including disciplinary action. In addition to the above, refer to G574, G580, andG590.	

	Functional mobility ... Home establishment/management, Meal prep/clean up." Patient's SOC was 1/31/25, and the POC for the initial certification period of 1/31/25 – 3/31/25 indicated an OT evaluation was to be completed, effective 02/09/25. The record included orders to reschedule Patient's OT evaluation on 2/11/25 and 3/04/25 by Patient Care Manager 3. The record failed to evidence the reason for the rescheduled visits and failed to evidence Patient was aware and in agreement with the rescheduled visits. The review of the record on 3/12/25 failed to evidence an OT evaluation had been completed. During an interview on 3/13/25 beginning at 12:56 PM, Patient reported he/she had needed assistance with ADLs after being discharged from the hospital, but he/she did not have any assistance available, so Patient "learned to do it myself." Patient reported they had an OT evaluation the morning of 3/13/25, which was the first time he/she had heard from the			

	agency regarding the OT evaluation. During an interview on 3/17/25 beginning at 8:32 AM, COTA 2 reported she had provided home health aide services to Patient. The OT assistant reported Patient did have a need for OT services, as Patient had decreased range of motion and needed assistance with ADLs. COTA 2 stated she thought OT 1 was going to conduct an OT evaluation visit, but was unsure of the reason the evaluation had not been done.During an interview on 3/13/25 beginning at 1:20 PM, OT 1 reported she had not been assigned an OT evaluation for Patient. During an interview on 3/13/25 beginning at 3:32 PM, Alternate Clinical Manager reported during Patient's SOC visit, the nurse had explained the agency only had one OT working with limited availability, so the OT service start could be delayed. The nurse was unable to provide documentation of patient notification and agreement with the delay in OT services.			

	During an interview on 3/13/25 beginning at 3:56 PM, Patient Care Manager 3 reported Patient had requested to reschedule the OT evaluation on 2/11/25 and 3/04/25. Patient Care Manager 3 was unable to provide documentation of these requests. 5. The review of Patient #13's clinical record indicated a SOC date of 8/27/24 and included an order for physical therapy services, effective 11/03/24, with visits once a week for 8 weeks. A PT re-evaluation note, documented 12/06/25 by PT 2, indicated Patient was to continue PT services to improve "strength and mobility … balance and safety." A PT visit note, documented 12/12/24 by PTA 4, indicated Patient would "continue to benefit from physical therapy to focus on balance activities, endurance training, transfer gait training." The record failed to evidence further PT visits were provided nor was a PT re-evaluation completed. The record included a POC for the recertification period of 12/25/24 – 2/22/25, which			

	indicated the only ordered service was skilled nursing. During an interview on 3/17/25 beginning at 12:18 PM, PT 2 reported he would "always" do a re-evaluation visit after a new certification period to determine if a patient's PT services should continue or if the patient could be discharged. The therapist could not recall the reason Patient's PT services did not continue nor the reason a PT re-evaluation was not done after Patient's recertification. 410 IAC 17-13-1(a) 4. Review of Patient #11's clinical record indicated Patient was referred to the agency on 01/06/24 for SN, PT, and OT due to "weakness, balance, and gait training." Patient #11 had a discharge date of 01/21/25 from a skilled nursing facility and a SOC date of 01/22/2025 with the home health agency. Patient #11 was noted to have left shoulder during the initial PT assessment on 01/24/25 with dressing upper extremities, reaching for items above Patient's head, and ADLs being activities with which the pain interfered.			

	The record included a verbal order entered by OT 3 on 01/23/2025 which included orders to move the OT evaluation to the following week (01/26/2025 to 02/01/2025) due to Patient #11's request. The record included an OT note for the initial OT evaluation conducted on 02/04/2025. The agency failed to conduct an OT evaluation during the period requested by the patient and ordered by the provider. The agency's complaint log included a Complaint Report documented by the Administrator on 02/06/2025. The report indicated Person 1 called the agency on 01/30/2025 and requested an update on when Patient #11's OT evaluation would be conducted. Person 1 reported they were "disappointed" with the delay in the OT evaluation. The log indicated Person 1 called the agency again on 02/03/2025 to follow-up on the complaint "solutions." During an interview on 03/17/2025, OT 3 indicated she normally assesses patients			

	the patient requests the assessment be moved, she will honor the patient's request. OT 3 further indicated she was the only OT for both the parent and branch locations of the agency at the time of Patient #11's SOC. OT 3 also indicated she had been on leave from work for a week at the end of January due to illness. During an interview on 03/17/2025 at 1:47 PM, RN 3 indicated she was Patient #11's RN case manager and indicated therapy evaluations should be conducted within 24 hours of an RN SOC. RN 3 also indicated the only reason she could think of for Patient #11 having a SOC of 01/22/2025 and receiving the initial OT evaluation on 02/04/2025 was the availability of OT 3. During an interview on 03/17/2025 at 1:28 PM, Person 1, caregiver for Patient #11, indicated Patient was home for 11 days with no shower because the OT evaluator was on leave. Person 1 indicated someone came out to assist Patient #11 with showers after they called regarding the delay. Person 1			

	not communicate with them about the OT evaluation delay until they called to ask about it.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and 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	G0574	Immediate action implemented to correct specificdeficiency: Patient # 1 medication list has been updated. Patient # 2 has been discharged from home healthservices. During a mandatory team meeting held on 3/27/25, theExecutive Director (ED) and Quality Department instructed all staff on maintainingan accurate medication list with emphasis on medication reconciliationreferencing Policy # 2.1.007 Plan of Care, Policy # 10.008 MonitoringMedications, and Medication Reconciliation Tip Sheet. For any staff unable to attend the mandatory training,1:1 remediation will be provided by	2025-04-16

	or allowed practitioner may choose to include. Based on observation, record review, and interview, the home health agency failed to ensure the POC included an accurate medication list for 2 of 7 home visit observations (Patient #1, 2). Findings include: 1. The agency policy "Monitoring Medications," last revised 7/01/24, indicated "all clinicians participating in the patient's care are responsible to assist with the maintenance of accurate patient medication information throughout the episode of care." 2. During the Entrance Conference on 3/05/25 beginning at 8:40 AM, Administrator reported all staff were to reconcile the patient's medications at each visit. The reconciliation was to be performed by comparing the medication bottles in the home against the agency's medication list. 3. During a home visit observation with Patient #1 on 3/06/25 beginning at 9:04 AM, PTA 1 reconciled Patient's medication bottles against the agency's medication list. The		prior toresuming patient care. 100% of active census to have medicationreconciliation completed via a home visit to ensure the medication list isaccurate and complete by 4/16/25. Physician will be notified and ordersobtained for any discrepancies identified. New process that will be implemented to preventdeficiency from re-occurring: A drug regimen review will be performed on allpatients in conjunction with all comprehensive assessments and additionally,all clinicians will participate in medication review and reconciliationthroughout the episode. For patients receiving skilled nursing and therapyservices, the skilled nurse is responsible for medication review andreconciliation throughout	

	agency's POC indicated Patient's active medications included Sertraline (a medication used to treat a variety of mental health disorders), however Patient kept the Sertraline separate from his/her active medication bottles, and Patient reported he/she was not taking this medication. During an interview on 3/06/25 beginning at 9:56 AM, Patient reported he/she had stopped taking Sertraline prior to being admitted to the home health agency. Patient reported the agency staff had reviewed Patient's medication bottles "maybe twice" since the SOC. 4. During a home visit observation with Patient #2 on 3/06/25 beginning at 10:49 AM, LPN 1 reconciled Patient's medication bottles against the agency's medication list and a list provided by Patient's physician. Patient's medication bottles included Tamsulosin (a medication used to treat an enlarged prostate) with a fill date of 11/11/24. The physician medication list also indicated Patient's active medications included Tamsulosin. The POC		participate bymonitoring and reporting any identified medication issues or non-compliance tothe Patient Care Manager (PCM). For patients receiving only therapy services, thetherapist is responsible to facilitate drug regimen review and medicationreconciliation throughout the episode. One therapy discipline will hold theprimary responsibility for medication reconciliation in therapy only episodesof care. When multiple therapy disciplines are being provided, the primaryresponsibility will be assigned as follows: Physical Therapy if ordered aloneor in conjunction with other therapy disciplines; Occupational Therapy ifordered alone or in conjunction with only Speech Therapy; and Speech Therapy ifonly discipline providing care to patient. The therapist will collaborate withthe Patient Care Manager to complete the process. The physician is contacted	

	failed to evidence Tamsulosin was an active medication. During an interview on 3/06/25 beginning at 11:49 AM, Patient reported he/she had been taking Tamsulosin prior to being admitted to the home health agency. 410 IAC 17-13(1)(a)(1)(D)(ix)		immediately if anydiscrepancies between agency information and patient medications are found, and updated orders areobtained as indicated. Title of person responsible for implementing plan ofcorrection: Executive Director Monitoring procedures to ensure effectiveness ofprocess improvement and continued compliance: Beginning 4/20/25, the ED, Clinical Director (CD), PCM,and/or Quality Department staff will complete 10 random observation visitsweekly to ensure the medication list is accurate and complete.	

			Monitoring will continue for 3 consecutive weeks anduntil 100% compliant for 2 consecutive weeks. Once compliance is achieved, the ED, Clinical Director(CD), PCM, and/or Quality Department staff will complete 5 random observationvisits weekly to ensure the medication list is accurate and complete. Monitoring will continue for 8 consecutive weeks anduntil 100% compliant for 4 consecutive weeks. The ED will report monitoring results to the QualityAssessment Performance Improvement (QAPI) Team quarterly until goals areachieved. For instances ofnon-compliance, immediate reconciliation and update of the deficient medicationprofile will	

			1:1 remediation up to and includingdisciplinary action.	
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 observation, record review, and interview, the home health agency failed to ensure wound care was performed according to the current physician order for 1 of 3 home visit observations of a SN visit where wound care was performed (Patient #7). Findings include: 1. The agency policy "Wound Assessment, Documentation, and Photography," last revised 9/01/24, indicated wound care was to be performed according to physician order. 2. The agency policy "Physician Orders," last revised 10/01/23, indicated services were to be provided "according to the most recent orders updating the patient's Plan of Care." 3. The review of Patient #7's clinical record indicated a start	G0580	Immediate action implemented to correct specificdeficiency: Occurrence report was entered for patient # 7 forfailure to adhere to physician orders. Patient # 7 physician was notified of failure toadhere to physician orders. 1:1 counseling with deficient RN related toinappropriate wound care was provided by the Executive Director (ED) on 3/27/25. During a mandatory team meeting held on 4/2/25 and4/3/25, the ED instructed all staff on adherence to physician orders with anemphasis on reviewing correspondence from wound clinic /physician and reducingorders to writing in Home Care Home Base (HCHB) and reviewing plan of care(POC)	2025-04-16

	of care date of 9/15/24. A POC for the recertification period of 1/13/25 – 3/13/25 indicated Patient was to receive skilled nursing services, with interventions to include performing wound care. Patient had two open diabetic ulcers to the left foot, including one diabetic ulcer to the left lateral foot. Patient's wounds were being managed by Entity B, a wound clinic. The record included Entity B's clinic notes dated 2/14/25 and received by the agency on 2/14/25. The visit note indicated wound care to Patient's left lateral wound included applying an Aquacel Ag Advantage dressing (a fiber wound dressing with ionic silver imbedded) and covering with a bordered gauze dressing, to be done three times a week. The record included Entity B's clinic notes dated 2/21/25 and received by the agency on 2/21/25. The visit note included a new order for wound care to Patient's left lateral wound included applying an IoPlex dressing (a wound dressing which slowly releases iodine) and covering with a bordered		and supplemental orders prior to each visit referencing Policy # 2.1.007Plan of Care, Policy # 2.1.008 Physician Orders, and Policy # 2.2.001 WoundAssessment, Documentation, and Photography. For any staff unable to attend the mandatory training,1:1 remediation will be provided by the ED or Clinical Director (CD) prior toresuming patient care. 100% of active census medical records for patientswith wounds to be reviewed to ensure wound care is completed the POC or mostcurrent orders updating the POC by 4/16/25. Physician will be notified andoccurrence report completed for any identified instances of non-compliance. New process that will be implemented to preventdeficiency from re-occurring:	

	gauze dressing, to be done three times a week. A SN visit note, documented on 2/26/25 by RN 2, indicated the nurse performed wound care to Patient's left lateral wound dressing, including applying an Aquacel Ag Advantage dressing, covering with an ABD (abdominal) gauze pad, and wrapping with Kerlix (a gauze wrap). The record failed to evidence the nurse had reviewed Entity B's clinic note from 2/21/25 and failed to evidence the nurse performed wound care according to the current order. A SN visit note, documented on 3/03/25 by RN 2, indicated the nurse performed wound care to Patient's left lateral wound dressing, including applying an Aquacel Ag Advantage dressing, covering with an ABD pad, and wrapping with Kerlix. The record failed to evidence the nurse had reviewed Entity B's clinic note from 2/21/25 and failed to evidence the nurse performed wound care according to the current order. The record indicated RN 2		Each patient has an individualized POC developed inconsultation with the patient, physician or authorized practitioner, and staffthat integrates comprehensive assessment findings to address patient problems,needs, and goals, as well as to address specific services being provided. Treatments and interventions are provided by qualifiedagency staff according the POC or most recent orders updating the POC asordered by the physician or authorized practitioner. No treatments or interventions will be completed withoutthe order of a qualified physician or authorizedpractitioner, and that order be reduced to writing and signed/dated by theordering physician. Physician/authorized practitioner's orders areobtained to update the POC when indicated.	

	apply an IoPlex dressing to Patient's left lateral wound. RN 2 documented a verbal order for this wound care was received on 2/28/25. During a home visit observation on 3/10/25 beginning at 3:18 PM, RN 2 was observed performing wound care to the left lateral wound. The nurse reported she had ordered a supply of IoPlex dressings on 3/05/25, however the agency had not yet received it. The nurse stated she had contacted Entity B earlier that day to verify alternative dressings which could be used, and received an order to use PolyMem (a foam dressing) until the IoPlex supply was received. During an interview on 3/17/25 beginning at 10:12 AM, RN 2 reported she called Entity B two to three times per week to verify Patient's wound care orders and reviewed the wound clinic's notes at each SN visit. RN 2 reported she received the order to change the left lateral wound's primary dressing from Aquacel to IoPlex through Entity B's 2/21/25 clinic note. RN 2 could not recall when she reviewed Entity B's clinic notes		Prior to each visit, the clinician will review the POCand supplemental orders to ensure care is provided as ordered. Documentation will reflect current interventions andtreatments provided to the patient. Physician orders received via email or fax will bereviewed by the Patient Care Manager (PCM) and reduced to writing with HCHBwhen received. Title of person responsible for implementing plan ofcorrection: Executive Director Monitoring procedures to ensure effectiveness ofprocess improvement and continued compliance:	

	and obtained the updated order. 410 IAC 17-13-1(a)		Beginning 4/20/25, the ED, Clinical Director (CD),PCM, and/or Quality Department staff will review 100% of medical records for thosepatients with wounds to ensure wound care is provided as ordered. Monitoring will continue for 3 consecutive weeks anduntil 100% compliant for 2 consecutive weeks. Once compliance is achieved, the ED, Clinical Director(CD), PCM, and/or Quality Department staff will 10 random medical records forpatients with wounds weekly to ensure wound care is completed as ordered. Monitoring will continue for 8 consecutive weeks anduntil 100% compliant for 4 consecutive weeks. The ED will report monitoring results to the QualityAssessment Performance	

			quarterly until goals areachieved. For instances of non-compliance, the ED will provide1:1 remediation up to and including disciplinary action. Physicianwill be notified of identified wound care deficits and corrected going forward.	
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the home health agency failed to notify the physician of changes in the patient's arm circumference measurement for 1 of 1 record reviewed of a patient with a PICC line (Patient #2) and failed to notify the physician of an increase in wound measurements for 2 of 3 home visit observations of a SN visit with wound assessment (Patient #6, 7). Findings include: 1. The agency policy	G0590	Immediate action implemented to correct specificdeficiency: Occurrence report was entered for patient's # 2, 6,and 7 for failure to notify physician of changes in condition. Patient # 2 has been discharged from home healthservices. Patient's # 6 and 7 physician was notified of increasein wound measurements. Clinicians identified through survey findings received1:1	2025-04-16

	"Coordination of Care, From Admit Through Discharge," last revised 9/01/24, indicated coordination of services was to be promoted through "routine communication with the patient's physician", including "when changes occur in the patient's condition or response to treatment." 2. The agency policy "Dressing Change Procedure for Central Venous, Midline, and Peripherally Inserted Central Catheters [PICC, a long IV placed into a large vein for medication infusions and/or blood draws]," last revised 10/01/16, indicated assessment during a PICC dressing change included measuring the upper arm circumference and comparing to the baseline measurement. The physician should be notified of "any significant findings in measurement as this may be indicative of a thrombus [blood clot]." 3. The review of Patient #2's clinical record indicated Patient was to receive SN services with interventions to include observing and assessing Patient's right upper arm PICC.		reeducation and competency assessment on measuring process and managementof PICC lines and wound measurements to ensure accuracy of documentation in themedical record on 3/26/25. During a mandatory team meeting held on 4/2/25 and4/3/25, the Executive Director (ED) instructed all staff on notifying thephysician of changes in the patient's condition with emphasis on increases in MACfor patients with Peripherally Inserted Central Catheters (PICC) and increasein wound measurements referencing Policy # 2.1.017 Coordination of Care, FromAdmit Through Discharge, Policy # 10.027 Dressing Change Procedure for CentralVenous, Midline, and Peripherally Inserted Central Catheters, and Policy #2.2.001 Wound Assessment, Documentation, and Photography. During a mandatory team meeting held on 4/2/25 and4/3/25, the Executive	

	Patient received four antibiotic infusions every day and had blood drawn weekly thru the PICC line. A RN start of care note, documented on 1/29/25 by Patient Care Manager 3, indicated Patient's right arm circumference (measurement taken above the PICC line to monitor for potential complications from the PICC) was 28.0 centimeters (cm). A SN visit note, documented on 2/21/25 by Patient Care Manager 3, indicated Patient's right arm circumference was 30.0 cm, an increase by 2 cm. The visit note failed to evidence Patient Care Manager 3 notified Patient's physician of the increase in PICC arm circumference. During an interview on 3/13/25 beginning at 3:49 PM, Patient Care Manager 3 reported she would report "any increase" in arm circumference when a patient had a PICC line. The nurse stated she had communicated the increase in arm circumference to Patient's physician, however she was unable to provide		Director (ED) and Wound Care Specialists instructed allstaff on wound assessment, with emphasis on measurements referencing Policy #2.2.001 Wound Assessment, Documentation, and Photography. Following the in-service, a skills lab was completedfor all staff completing PICC and wound care to complete competency assessmenton PICC dressing changes, including MAC, and wound measurements. For any staff unable to attend the mandatory training,1:1 remediation will be provided by the ED or Clinical Director (CD) prior toresuming patient care. 100% of active census medical records for patientswith PICC lines and wounds to be reviewed to ensure physician was notified ofincrease in mid arm circumference or wound measurements by 4/16/25 Physicianwill be notified and occurrence report completed	

	documentation of this communication. 4. The review of Patient #6's clinical record indicated Patient was to receive SN services with interventions to include assessing Patient's wounds. Patient had open ulceration wounds to both lower legs. Patient's POC indicated potential wound complications included "increase in wound size," and Patient's goals included "improved wound status as evidenced by decrease in size …." A SN visit note, documented on 2/19/25 by LPN 2, indicated Patient's left lower leg wound measured 5 cm in length by 27 cm in width by 0.2 cm in width (5 cm x 27 cm x 0.2 cm). A RN recertification note, documented on 3/03/25 by RN 3, indicated Patient's right lower leg wound measured 4 cm x 8 cm x 0.4 cm and the left lower leg wound measured 5 cm x 7 cm x 0.2 cm. During a home visit observation with Patient #6 on 3/10/25 beginning at 12:56 PM, LPN 2 was observed measuring Patient's leg wounds. Patient		for any identified instancesof non-compliance. 100% of wounds will be remeasured to ensure anaccurate baseline measurement by 4/16/25. New process that will be implemented to preventdeficiency from re-occurring: Coordination of care with the physician/authorized practitionerwill occur throughout the episode of care through routine communication withthe patient's physician when changes occur in the patient's condition orresponse to treatment occur, including increases in mid arm circumference orwound measurements. With each PICC line dressing change, MAC(approximately 5cm above exit site) will be obtained and compared to the baselinemeasurement. The	

	had large wounds to both legs, covering both the anterior and posterior leg, with “islands” of skin scattered throughout. LPN 2 noted Patient’s right lower leg wound measured 6 cm x 10 cm x 0.1 cm, an increase of 2 cm in length and 2 cm in width from the previous measurement. The left lower leg wound measured 5 cm x 36 cm x 0.1 cm, an increase in 29 cm in width from the previous measurement. The record failed to evidence LPN 2 notified Patient’s physician of the increase in wound measurements. During an interview on 3/14/25 beginning at 3:36 PM, LPN 2 reported no changes in Patient’s wounds were noted during the 3/10/25 visit, so the nurse had not reported any changes to Patient’s physician. LPN 2 stated she would report any change in wound measurements to Patient’s physician. When asked if LPN 2 had noted the increase in her wound measurements when compared with the previous measurements, the nurse stated no and thought the wounds had been measured incorrectly by RN 3.		physician will be notified of any significant findings inmeasurement as this may be indicative of a thrombus. Wound assessment findings will be documented withinthe Integumentary Command Center by utilizing the Wound Assessment Tool, withinHCHB computer system. Clinician will assess wounds at least weekly for patient receiving negative pressurewound therapy, receiving daily wound care performed by the agency, have an infected wound, orhave stage IV pressure injury with evidence of infection or exposed bone, tendon, or muscle tissueand every other week for patients receiving wound care by the agency at afrequency less than daily.	

	5. The review of Patient #7's clinical record indicated Patient was to receive SN services with interventions to include assessing Patient's wounds. Patient had two open diabetic ulcers to the left foot, including one to the posterior foot and one to the lateral (side) foot. Patient's POC indicated potential wound complications included "increase in wound size," and Patient's goals included "improved wound status as evidenced by decrease in size …." A SN visit note, documented on 1/27/25 by LPN 3, indicated Patient's left lateral wound was new and measured 5.5 cm x 2.8 cm x 0.1 cm. A SN visit note, documented on 1/30/25 by RN 2, indicated Patient's left lateral wound measured 7 cm x 5 cm by 0.2 cm, an increase of 1.5 cm in length and 2.2 cm in width. The record failed to evidence RN 2 notified Patient's physician of the increase in wound measurements. During an interview on 3/17/25 beginning at 10:12 AM, RN 2 stated she would report an		Wound assessment will include the measurement of thelength, width, and depth, undermining and tunneling, wound bed description,wound edges, exposed tissue types, drainage, and the condition of the peri wound. Wound size is measured as: Length, Width and Depth aremeasured in centimeters with length measured from 12:00-6:00 and width measuredfrom 3:00-9:00, unless otherwise noted. Depth is measured at the deepest areausing cotton tipped applicator (CTA) or foam tipped applicator (FTA).Undermining and/or Tunneling: Measure location and depth using a CTA or FTA and document according to the clock. Increase in wound measurements are to be reported tothe physician. Clinician will contact the Patient	

	increase in wound measurements to the physician. The nurse thought she had left a message with Patient's wound clinic regarding the increase in size after the 1/30/25, however she was unable to provide documentation of this communication. 410 IAC 17-13-1(a)(2)		Care Manager (PCM)at the end of each day to report on status of patients with PICC lines orwounds, specifically changes in measurements. Title of person responsible for implementing plan ofcorrection: Executive Director Monitoring procedures to ensure effectiveness ofprocess improvement and continued compliance: Beginning 4/20/25, the ED, Clinical Director (CD),PCM, and/or Quality Department staff will review 100% of medical records forthose patients with PICC lines or wounds to ensure the physician was notifiedof increases in MAC or wound measurements.	

			Monitoring will continue for 3 consecutive weeks anduntil 100% compliant for 2 consecutive weeks. Once compliance is achieved, the ED, Clinical Director(CD), PCM, and/or Quality Department staff will 10 random medical records forpatients with PICC lines or wounds weekly to ensure physician was notified ofincrease in MAC or wound measurements. Monitoring will continue for 8 consecutive weeks anduntil 100% compliant for 4 consecutive weeks. The ED will report monitoring results to the QualityAssessment Performance Improvement (QAPI) Team quarterly until goals areachieved. For instances of non-compliance, the ED will provide1:1 remediation up to	

			and including disciplinary action.	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, policy review, and interview, the home health agency failed to ensure all staff followed standard precautions and infection control policies and procedures for 6 of 7 home visit observations (Patient #1, 2, 3, 4, 5, 6). Findings include:	G0682	Immediate action implemented to correct specific deficiency: Executive Director (ED) instructed and completedskills lab with LPN 1 with emphasis on Peripherally Inserted Central Catheter(PICC) site care and cap cleansing. During a mandatory team meeting held on 4/2/25 and4/3/25, the Executive Director (ED) instructed all staff on PeripherallyInserted Central Catheter (PICC) dressing changes and flushing with emphasis onglove changes, proper cleansing of site and cap referencing Policy # 10.027Dressing Change Procedure for Central Venous, Midline, and PeripherallyInserted Central Catheters and Venous Catheter: Flushing and Locking (HomeHealth Care) - CE/NCPD Clinical Skill.	2025-04-16

	1. The agency policy "Hand Hygiene," last revised 5/01/19, indicated staff were to perform hand hygiene "after contact with … non-intact skin, wound dressings … if moving from a contaminated body site to a clean body site during patient care, after contact with inanimate objects … in the immediate vicing of the patient, before and after removal of personal protective equipment (PPE) …." 2. The agency policy "Dressing Change Procedure for Central Venous, Midline, and Peripherally Inserted Central Catheter [PICC]," last revised 10/01/16, indicated during a PICC line dressing change, staff should don clean gloves, remove the old PICC dressing, remove gloves and perform hand hygiene, then don sterile gloves. After inspecting the catheter site, staff should cleanse the site with chlorohexidine in "a back and forth motion." When povidone-iodine is used, staff should apply the disinfectant in "a circular motion, moving from the catheter insertion site outward in concentric circles."		During a mandatory team meeting held on 4/2/25 and4/3/25, the Executive Director (ED) instructed all staff on infection control withemphasis on equipment cleaning, hand hygiene, and glove changes during woundcare referencing Policy # 8.004 Hand Hygiene, Policy # 8.006 Cleaning ofRe-Usable Equipment, and the Wound Care Best Practices Checklist. Following the in-service, a skills lab was completedfor all staff completing PICC and wound care to complete competency assessmenton infection control, PICC dressing changes, and wound care on 4/2/25 and4/3/25. For any staff unable to attend the mandatory training,1:1 remediation will be provided by the ED or Clinical Director (CD) prior toresuming patient care. Clinicians involved in the survey	

	3. An untitled agency procedure indicated when flushing a PICC line, staff should scrub the needleless connector "using a vigorous mechanical scrubbing for a minimum of 5 seconds with an appropriate disinfecting agent" prior to attaching a flush syringe. Staff should repeat the procedure prior to connecting a heparin lock syringe. 4. The agency policy "Cleaning of Re-Usable Equipment," last revised 6/01/22, indicated "non-critical items," such as stethoscopes, blood pressure cuffs, and pulse oximeters, would be cleaned with a disinfectant "after each patient use and before returning to staff bags." 5. The manufacturer's instructions for CaviWipes, obtained from www.metrex.com, indicated the dry time for the disinfectant wipes was 3 minutes. 6. During a home visit observation with Patient #1 on 3/06/25 beginning at 9:04 AM, PTA 1 was observed obtaining Patient's vital signs and measuring Patient's ankles. PTA then failed to perform hand		findings received1:1 reeducation and competency assessment on 4/2/25 and 4/3/25. New process that will be implemented to preventdeficiency from re-occurring: PICC dressing will be changed using the followingprocedure: 1. Identify patient using 2 patient identifiers. 2. Explain procedure to patient. 3. Perform hand hygiene and don PPE (e.g., cleangloves and mask). 4. Place moisture proof pad under patient's arm. 5. To remove the old dressing, lift edge of dressingbeginning at catheter hub and gently pull dressing perpendicular to the skin toward theinsertion site. Remove catheter securement device	

	hygiene prior to donning gloves. During an interview on 3/06/25 beginning at 9:52 AM, PTA 1 reported she should perform hand hygiene after contact with a patient and prior to donning gloves. 7. During a home visit observation with Patient #2 on 3/06/25 beginning at 10:49 AM, LPN 1 was observed performing a PICC line dressing change. After removing the old dressing, the nurse failed to change her gloves, perform hand hygiene, and don new sterile gloves prior to cleaning the PICC. When cleansing the site, LPN 1 failed to apply the disinfectant to the PICC insertion point. After completing the PICC dressing change, LPN 1 scrubbed the needless connector with an alcohol swab for 2 seconds prior to connecting the initial line flush and prior to connecting the heparin lock flush. During an interview on 3/06/25 beginning at 11:43 AM, LPN 1 reported during a PICC line dressing change, she should change her gloves and perform		and chlorhexidine-impregnated sponge (if present). 6. Discard dressing in appropriate receptacle. 7. Remove gloves, perform hand hygiene, and donsterile gloves. 8. Inspect catheter, catheter exit site, andsurrounding skin and patient's arm, chest, and neck area. 9. Cleanse the site with chlorhexidine (preferred) ina back-and-forth motion for at least 30 seconds. If povidone-iodine is used,use swabs to apply in a circular motion, moving from the catheter insertionsite outward in concentric circles. 10. Allow solution to air dry completely(approximately 30 seconds for chlorhexidine; at least 2 minutes or longer forpovidone-iodine). 11. Consider application of achlorhexidine-impregnated sponge to the site, particularly if all other institutional efforts to decrease rates of BSI havefailed to	

	hand hygiene between removing the old dressing and cleaning the site. The nurse reported she cleaned Patient's PICC line with alcohol then betadine (a povidone iodine solution). LPN 1 stated she did not realize she had failed to clean the PICC insertion site with disinfectant. LPN 1 reported the needless connector should be scrubbed with alcohol for "30 seconds" prior to connecting a flush or lock syringe. When asked if the nurse had done this during the visit, LPN 1 reported she had sung the "happy birthday" song in her head as a method of counting, but had done it "quickly." 8. During a home visit observation with Patient #3 on 3/06/25 beginning at 2:38 PM, PT 2 was observed wiping reusable equipment including a stethoscope, manual blood pressure cuff, thermometer, and pulse oximeter with CaviWipes disinfectant wipes. After wiping the equipment, PT 1 placed them immediately into his supply bag, failing to allow the disinfectant to dry. During an interview on 3/06/25		produce the desired reduction. 12. Secure the catheter in place. The use of asutureless stabilization device is preferred to tape and sutures. 13. Apply a sterile dressing to the site. Use either atransparent, semipermeable dressing alone, or a gauze dressing with tape. If the patient isdiaphoretic or if the site is bleeding or oozing, a gauze dressing is preferred. 14. Document the date and time the dressing wasapplied, and initials on the external dressing. 15. Discard used supplies, remove gloves and PPE, andperform hand hygiene. 16. Document the procedure in the patient's record. Prior to flushing a PICC line, disinfect theconnection surface and sides of the needleless connector using vigorousmechanical scrubbing	

	beginning at 3:20 PM, PT 2 reported the dry time for CaviWipes disinfectant wipes was “around 60 seconds.” 9. During a home visit observation with Patient #4 on 3/10/25 beginning at 9:03 AM, RN 1 was observed performing wound care to an open wound. After cleansing the wound, the nurse failed to change gloves and perform hand hygiene prior to applying a new, clean dressing. During an interview on 3/10/25 beginning at 9:56 AM, RN 1 reported during wound care, she should change her gloves and performed hand hygiene at the start of the procedure, after removing the old dressing, and after completing the procedure. 10. During a home visit observation with Patient #5 on 3/10/25 beginning at 11:00 AM, OT 3 was observed conducting an OT re-evaluation visit. The therapist failed to perform hand hygiene after removing gloves on two occasions. During an interview on 3/10/25 beginning at 11:54 AM, OT 3 reported she should perform hand hygiene after removing		isopropyl alcohol oralcohol-based chlorhexidine suitable for use with medical devices. Allow thesolution to dry. Staff are required to perform hand hygiene specifiedtime points during and following patient contact including before and afterremoval of personal protective equipment (PPE). Hand hygiene will be performedusing soap and water or an alcohol – based hand sanitizer. Equipment used for more than one patient is cleanedbetween each patient use and prior to returning to the home care bag. Non-critical items which will encounter intact patientskin will undergo a low-level disinfection between each patient use. Dry timefor low level disinfectant will be allowed before returning the item to thehome care bag. The following procedure will be	

	gloves if her hands had been soiled while wearing gloves. 11. During a home visit observation with Patient #6 on 3/10/25 beginning at 12:56 PM, LPN 2 was observed conducting a SN visit. Patient was noted to have an active shingles rash to the left lateral (side) chest and back. The nurse failed to perform hand hygiene after removing gloves on two occasions, including after assessing Patient's shingles rash. During an interview on 3/10/25 beginning at 2:03 PM, LPN 2 reported she should perform hand hygiene after removing gloves. The nurse stated Patient's shingles rash began draining on 3/07/25, and the nurse noted Patient's T-shirt had drainage from the rash on it. 12. During an interview with CM, Alternate CM, and Patient Care Manager 3 on 3/12/24 beginning at 9:20 AM, the administrative staff reported staff should perform hand hygiene before and after changing gloves, with "every		utilized whenperforming wound care: 1. Gather supplies for procedure. 2. Open dressings, unwrap equipment, apply protectiveequipment and/or gloves 3. Remove dressing and discard. 4. Remove gloves and perform hand hygiene 5. Apply new gloves 6. Assess wound 7. Adequately cleanse wound 8. Remove and discard gloves and perform hand hygiene 9. Apply new gloves 10. Apply dressing 11. Remove gloves and perform hand hygiene 12.. Apply new gloves 13. Label dressing with date/time of application andclinician's initials	

	when hands were soiled. When changing a PICC line dressing, staff should change gloves and perform hand hygiene after removing the old dressing, clean directly at the PICC insertion site, and scrub the needless connector with an alcohol wipe for five seconds prior to connecting syringes. The administrative staff reported staff should allow equipment wiped with disinfectant to dry prior to returning it to their supply bag, and the nurse should change gloves and perform hand hygiene between cleaning an open wound and applying a new dressing. 410 IAC 17-12-1(m)		14. Remove gloves and perform hand hygiene Title of person responsible for implementing plan ofcorrection: Executive Director Monitoring procedures to ensure effectiveness ofprocess improvement and continued compliance: Beginning 4/20/25, the ED, Clinical Director (CD),PCM, and/or Quality Department staff will complete 10 random observation visitsof patients receiving PICC line or wound care weekly to ensure proper techniqueand infection control measures are adhered to. Monitoring will continue for 3 consecutive weeks anduntil 100% compliant for 2 consecutive weeks.	

			Once compliance is achieved, the ED, Clinical Director(CD), PCM, and/or Quality Department staff will complete 5 random observation visitsof patients receiving PICC line or wound care weekly to ensure proper techniqueand infection control measures are adhered to. Monitoring will continue for 8 consecutive weeks anduntil 100% compliant for 4 consecutive weeks. The ED will report monitoring results to the QualityAssessment Performance Improvement (QAPI) Team quarterly until goals areachieved. For instances of non-compliance, the ED will provide1:1 remediation up to and including disciplinary action.	

G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; Based on observation, record review, policy review, and interview, the skilled professional failed to use an appropriate sized blood pressure (BP) cuff to assess a patient's BP for 2 of 7 home visit observations (Patient #1, 7), failed to perform a complete assessment of a patient's lung, heart, and bowel sounds for 3 of 7 home visit observations (Patient #2, 3, 5), failed to conduct a complete assessment of a patient's wound and cough for 1 of 3 home visit observations of a SN visit with wound care (Patient #4), and failed to perform a complete medication reconciliation for 1 of 1 home visit observations of an OT re-evaluation visit (Patient #5). Findings include: 1. The agency policy "Monitoring Medications," last revised 7/01/24, indicated "all clinicians participating in the patient's care are responsible to assist with the maintenance of accurate patient medication information throughout the episode of care." Staff were to "compare medications [the]	G0706	Immediate action implemented to correct specificdeficiency: During a mandatory team meeting held on 4/2/25 and4/3/25, the Executive Director (ED) instructed all staff on assessment of thepatient with emphasis on proper blood pressure (B/P) cuff size and completepatient assessment referencing American Heart Association / American MedicalAssociation Measuring Blood Pressure Accurately presentation, Policy #2.1.002Patient Assessment, Initial and Reassessment, Policy # 7.003 Home Care Record,and Policy # 2.2.001 Wound Assessment, Documentation, and Photography. During a mandatory team meeting held on 3/27/25, theExecutive Director (ED) and Quality Department instructed all staff on medicationreconciliation with an emphasis on the procedure, frequency, and staffresponsible referencing Policy # 10.008	2025-04-16

	patient is currently taking with medications ordered for the patient in order to identify and resolve discrepancies." 2. The agency policy "Wound Assessment, Documentation, and Photography," last revised 9/01/24, indicated the wound assessment should include a measurement of the wound's depth, taken at "the deepest area using [a] cotton tipped applicator …." 3. An untitled agency procedure on BP measurement indicated the BP cuff's bladder (inflatable tube inside the cuff which expands to measure BP) "should be proportionate to the limb circumference," and "an improperly sized cuff produces an inaccurate BP measurement." 4. American Heart Association guidance titled "Measuring Blood Pressure Accurately," obtained from www.heart.org, indicated the length of the BP cuff's bladder should be "75 – 100%" of the Patient's measured arm circumference. 5. During a home visit observation with Patient #1 on 3/06/25 beginning at 9:04 AM,		Monitoring Medications and MedicationReconciliation Tip Sheet. For any staff unable to attend the mandatory training,1:1 remediation will be provided by the ED or Clinical Director (CD) prior toresuming patient care. New process that will be implemented to preventdeficiency from re-occurring: B/P Assessment: B/P will be assessed utilizing proper size cuff. Cufflength shall be 75- 100% of the patients measured arm circumference and cuffwidth shall be 37- 50% of the patients arm circumference. Provider maintains additional sized B/P cuffs in officefor use as indicated.	

	Patient’s BP. The therapy assistant used a standard-sized BP cuff on Patient’s upper arm. The cuff’s bladder length was less than 75-80% of Patient’s arm circumference, indicating the cuff was too small. PTA 1 reported Patient's BP was "96/58." Review of Patient's clinical record evidenced three of Patient's previous blood pressure readings were: a. 112/62 on 3/04/25 b. 118/68 on 2/26/25 c. 142/79 on 2/17/25 During an interview on 3/06/25 beginning at 9:52 AM, PTA 1 reported she only had a standard sized BP available. The PT assistant stated she would take a patient’s BP in their lower arm if the cuff was too small. 6. During a home visit observation with Patient #2 on 3/06/25 beginning at 10:49 AM, LPN 1 was observed performing a SN visit. The nurse failed to listen for lung sounds in all lung lobes and for bowel sounds in all abdominal quadrants.		Physical Assessment: Upon admission and reassessments, the qualifiedclinician performs the following assessment activities and collects the following data:current health status, psychosocial, functional, and cognitive status; and pertinentphysical findings, including cardiovascular status, respiratory status,gastrointestinal / elimination status Wound assessment: Depth is measured at the deepest area using cottontipped applicator (CTA) or foam tipped applicator (FTA). Medication reconciliation:	

	During an interview on 3/17/25 beginning at 8:38 AM, LPN 1 reported a SN assessment included listening for lung sounds in all lung lobes, both anteriorly and posteriorly, and listening for bowel sounds in all abdominal quadrants. 7. During a home visit observation with Patient #3 on 3/06/25 beginning at 2:38 PM, PT 2 was observed conducting a PT re-evaluation visit. The therapist failed to assess Patient's lung sounds, heart tones, and bowel sounds during the visit. During an interview on 3/17/25 beginning at 12:11 PM, PT 2 reported during a PT re-assessment visit, the assessment would include listening to lung sounds, heart tones, and bowel sounds. PT 2 reported he did not assess these for Patient during the 3/06/25 visit due to Patient reporting during the previous visit on 1/30/25 that Patient "didn't like" the stethoscope on his/her chest and back. The review of PT 2's visit note from 1/30/25 evidenced PT 1 had assessed Patient's lung		A drug regimen review will be performed on allpatients in conjunction with all comprehensive assessments and additionally,all clinicians will participate in medication review and reconciliationthroughout the episode. For patients receiving skilled nursing and therapyservices, the skilled nurse is responsible for medication review and reconciliationthroughout the episode. The therapist will participate by monitoring andreporting any identified medication issues or non-compliance to the PatientCare Manager (PCM). For patients receiving only therapy services, thetherapist is responsible to facilitate drug regimen review and medicationreconciliation throughout the episode. One therapy discipline will hold theprimary responsibility for medication reconciliation in therapy only episodesof care. When multiple therapy	

	sounds and bowel sounds during the visit. The record failed to evidence Patient had declined the assessment or had requested no further lung, heart, or bowel sound assessments. 8. During a home visit observation with Patient #4 on 3/10/25 beginning at 9:03 AM, Patient reported a productive cough to RN 1. The nurse failed to conduct a further assessment of the cough, including the sputum color, consistency, and amount. RN 1 performed a wound assessment to Patient's right forearm open wound. RN 1 failed to measure the depth of the wound as part of the wound assessment. During an interview on 3/10/25 beginning at 9:56 AM, RN 1 reported Patient had a history of COPD (Chronic Obstructive Pulmonary Disease, a progressively worsening lung disease). The nurse reported she did not assess the color or consistency of Patient's sputum. She reported Patient had previously reported the sputum was "creamy" in color and consistency.		the primaryresponsibility will be assigned as follows: Physical Therapy if ordered aloneor in conjunction with other therapy disciplines; Occupational Therapy ifordered alone or in conjunction with only Speech Therapy; and Speech Therapy ifonly discipline providing care to patient. Title of person responsible for implementing plan ofcorrection: Executive Director Monitoring procedures to ensure effectiveness ofprocess improvement and continued compliance: Beginning 4/20/25, the ED, Clinical Director (CD),PCM, and/or Quality Department staff will complete 10 random observation visits,to include sample of patients receiving wound care, weekly to ensure proper assessmentand medication reconciliation is completed.	

	During an interview on 3/10/25 beginning at 10:03 AM, Patient reported their sputum was clear to brown in color and had a thin consistency. 9. During a home visit observation with Patient #5 on 3/10/25 beginning at 11:00 AM, OT 3 was observed conducting an OT re-evaluation visit. The therapist reconciled Patient's medication bottles against the agency's medication list. OT 3 failed to review the medication bottles or verify if Patient was still taking Melatonin (a supplement used to treat insomnia), Mirtazepine (a medication used to treat depression), Metamucil (a medication used to treat constipation), and Repatha (an injected medication used to treat high cholesterol). The therapist also failed to listen for lung sounds in all lung lobes and for bowel sounds in all abdominal quadrants. During an interview on 3/10/25 beginning at 11:54 AM, OT 3 reported she reconciled Patient's medications by comparing Patient's medication bottles against the agency's medication list. The therapist		Monitoring will continue for 3 consecutive weeks anduntil 100% compliant for 2 consecutive weeks. Once compliance is achieved, the ED, Clinical Director(CD), PCM, and/or Quality Department staff will complete 5 random observationvisits, to include sample of patients receiving wound care, weekly to ensureproper assessment and medication reconciliation is completed. Monitoring will continue for 8 consecutive weeks anduntil 100% compliant for 4 consecutive weeks. The ED will report monitoring results to the QualityAssessment Performance Improvement (QAPI) Team quarterly until goals areachieved. For instances ofnon-compliance, the ED will	

	reported she did not observe a bottle or verify Patient was taking Melatonin, Mirtazepine, Metamucil, or Repatha. OT 3 also reported she assessed Patient's lung sounds by listening to the left upper lobe only and assessed Patient's bowel sounds by listening to the midline upper abdomen only. 10. During a home visit observation with Patient #1 on 3/10/25 beginning at 3:18 PM, RN 2 was observed obtaining Patient's BP. The nurse used a standard-sized BP cuff on Patient's upper arm. The cuff's bladder length was less than 75-80% of Patient's arm circumference, indicating the cuff was too small. RN 2 reported Patient's BP was "104/60." Review of Patient's clinical record indicated Patient's three previous blood pressure readings were as follows- a. 140/82 on 3/05/25 b. 128/64 on 3/03/25 c. 128/68 on 2/26/25 During an interview on 3/17/25		provide 1:1 remediation up to and includingdisciplinary action.	

	beginning at 10:12 AM, RN 2 reported she used a standard sized BP cuff on all patients unless the cuff would not go all the way around a patient's arm and the Velcro would not stick securely. 11. During an interview with CM, Alternate CM, and Patient Care Manager 3 on 3/12/24 beginning at 9:20 AM, the administrative staff reported if a BP cuff was too small, staff should use a larger cuff or take the BP reading on an alternative site. CM reported staff should reconcile the patient's medications at each visit by comparing the medication bottles in the home against the agency's medication list. If a medication was included on the agency's list but not observed in the home, staff should investigate if Patient was still taking the medication. The administrative staff reported the nurse should assess a wound's depth when measuring an open wound, the nurse should assess a patient's cough "quality," including sputum color and consistency, when a patient reported a productive cough, and the therapist should "check all systems" at every visit,			

	including listening to all lung lobes, heart tones, and all bowel quadrants. 410 IAC 17-14-1(a)(1)(b), 17-14-1(a)(2)(A), 17-14-1(c)(3)			
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: March 5, 6, 10, 12, 13, 14, and 17, 2025 12-Month Unduplicated Skilled Admissions: 1158	N0000		

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
Angela Schave	RN Executive Director	4/4/2025 3:04:08 PM