STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157560	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE	**5701 ELMWOOD AVE STE N , INDIANAPOLIS, Indiana, 46203**

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 Survey Dates: 03/10/2025, 03/11/2025, and 03/12/2025. Active Census: 173 At this Emergency Preparedness survey, Best Choice Home Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102 QR completed by Area 3 on 3/13/2025.	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: 03/10/2025, 03/11/2025, and 03/12/2025 12-Month Unduplicated Skilled Admissions: 789 RN Registered Nurse PT Physical Therapist PTA Physical Therapy Assistant OT Occupational Therapist ST Speech Therapist QR completed by Area 3 on 3-13-2025.	G0000		
G0514	RN performs assessment CFR(s): 484.55(a)(1)	G0514		

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

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

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G0514	Continued from page 1 A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. This ELEMENT is NOT MET as evidenced by: Based on record review and interviews the Agency failed to ensure admissions occurred within 48 hours of receiving/accepting the patients with 2 of 4 active clinical records reviewed who received Physical, Occupation and Speech therapy services. (Patients #10 and 16) Findings include: 1. A review of a policy titled, 'Admission Procedure Policy Number: 201" stated, "… 6. … to determine the immediate care and support needs of the client; and for Medicare clients, to determine eligibility for Medicare home health benefits. The initial assessment will be completed within forty -eight (48) hours of referral …" 2. A review of the Clinical Record for Patient #16 evidenced a Referral Order dated 01/10/2025 which was faxed to the Agency 01/10/2025 at 9:50 PM for Physical Therapy and Plan of Care with a start of care date of 01/18/2025. The Clinical Record also contained a physician's order signed by the Administrator on 01/16/2025 for Physical Therapy assessment and evaluation. The record failed to evidence Physician or Patient communication notes/notifications for the late admission. 3. On 03/12/2025 at 10:55 AM, during an interview with Person G, a patient representative for Patient #16 indicated they knew the agency had to get insurance approval but hadn't realized it would take as long as it did. On 03/11/2025 at 1:25 PM during an interview, the Administrator indicated with insurance, they cannot	G0514		

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G0514	Continued from page 2 move forward with visits until they get the insurance approval, and they try to keep the patients, family members, and physicians informed. 4. A review of the Clinical Record for Patient #10 evidenced a Referral Order dated 01/30/2025 and a Plan of Care with a start of care date of 02/07/2025. The record failed to evidence communication notes for the late admission. 5. During an interview with the Administrator on 03/11/2025 at 1:00 PM, she indicated the face to face visit was on 02/05/2025 and confirmed the start of care date of 02/07/2025 for Patient # 10. 410 IAC 17-14-1(a)(1)(A)	G0514		
G0576	All orders recorded in plan of care CFR(s): 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure an individualized plan of care included all wounds and corresponding wound care orders, in 1 of 5 active clinical records reviewed, who received skilled nursing services for wound care. (Patient #13) Findings include: 1. A review of an agency policy dated 05/19/2022, titled 'Plan of Care' stated, "… Home Health services are furnished … based on a plan of care … to ensure application of services to the patient … 3. The plan of care includes the following: … n) specific procedures and treatments to be performed … 4. Care provided patients by all disciplines follows the established plan of care …" 2. A review of the clinical record for Patient #13 with a Start of Care date of 02/07/2025 and an initial certification period of 02/07/2025 to 04/07/2025, contained diagnoses which included, but were not limited to: diabetes mellitus (a chronic condition where the body does not use or produce insulin	G0576		

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G0576	Continued from page 3 effectively, leading to high blood sugar levels) with foot ulcers, non-pressure ulcer of the left foot, pressure ulcer of the right heel stage 3. The record indicated Patient #13 had multiple wounds and their wound care was being managed and provided by Entity A, a wound care center, every Tuesday, with instruction for the home health nursing to provide wound care twice weekly, and the nursing staff at Entity B, an assisted living facility (ALF) where the patient resided, provided wound care the remaining 4 days. The clinical record contained wound care orders from Entity A dated 02/11/2025 for four (4) wounds. Subsequent wound care orders from Entity A dated 02/18/2025, evidenced a new, 5th wound had been identified on the left lateral foot. Wound care orders for the new site included, "… Clean with normal saline and pat dry 1. Apply maxorb Ag to open wounds 2. cover with gauze pad. 3. Wrap kerlix and secure dressing with tape. Change daily for one week per providers orders HHC [home health care] is able to complete twice weekly during approved SN visits …" The plan of care dated 02/07/2025 contained wound care orders, to be performed to four (4) sites: wound #1 - left 3rd toe, wound #2 - left 2nd toe, wound #3 - left medial great toe, and wound #4 - right heel. The Plan of Care failed to evidence the addition of a fifth wound on 02/18/2025, and failed to integrate corresponding wound care orders. 3. On 03/12/2025 at 9:06 AM, RN 1 confirmed had been providing care for Patient #13 and indicated had been caring for, "four wounds … well, four and a half", and had also provided wound care to the newest site, the left lateral foot (wound #5). RN 1 indicated this was more of a "protection" to the site, but realized care provided to the additional site had not been documented in the skilled nursing visit notes. On 03/12/2025 at 9:20 AM, when queried, the Administrator informed new interim orders can be added to a patient's plan of care, in order to update the plan of care but "… the nurse will write it, that's the only way it gets updated …". The Administrator indicated had not been aware RN 1 had not documented regarding Patient #13's additional wound to the left lateral foot.	G0576		

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G0576	Continued from page 4 On 03/12/2025 at 12:00 PM, RN 1 indicated was not certain of the date of discovery of wound #5 to Patient #13's left lateral foot, but may have been 02/25/2025. RN 1 indicated the area had not been open, appeared to be irritated probably from the patient's shoe rubbing the area, but the site had only ever appeared irritated or flaky. And indicated further the patient insists on showering before the nursing visit, so the site is clean and without a dressing when they arrive. On 03/12/2025 at 10:41 AM, the Administrator indicated after a brief review of the chart for Patient #13 noted the nurse would have to create a new wound in the record's 'wound manager' and this would have updated the plan of care. The Administrator indicated would have liked to have seen the additional order for the left lateral wound and the subsequent care provided to Patient #13 had been documented, or would have liked if the RN had called and communicated with the wound center regarding the site in question having no opening.	G0576		
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure all treatments ordered by a physician were carried out, in 1 of 6 active clinical records reviewed, receiving only skilled nursing services for wound care. (Patient #13) Findings include: 1. A review of an agency policy dated 04/29/2021, titled 'Physician Interim Order/Verbal Order' stated, "… treatments are administered by agency staff only as ordered by the physician … 10. All interim orders are included in the patient's clinical record …" 2. A review of the clinical record for Patient #13 with a Start of Care date of 02/07/2025 and an initial certification period of 02/07/2025 to 04/07/2025, contained diagnoses which included, but were not limited to: diabetes mellitus with foot ulcers, non-pressure ulcer of the left foot, pressure ulcer of	G0580		

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G0580	Continued from page 5 the right heel stage 3. The record indicated Patient #13 had multiple wounds and their wound care was being managed and provided by Entity A, a wound care center, every Tuesday, with instruction for the home health nursing to provide wound care twice weekly, and the nursing staff at Entity B, an assisted living facility (ALF) where the patient resided, provided wound care the remaining 4 days. The clinical record contained wound care orders from Entity A dated 02/11/2025 for four (4) wounds. Subsequent wound care orders from Entity A dated 02/18/2025, evidenced a new, 5th wound had been identified on the left lateral foot. Wound care orders for the new site included, "… Clean with normal saline and pat dry 1. Apply maxorb Ag to open wounds 2. cover with gauze pad. 3. Wrap kerlix and secure dressing with tape. Change daily for one week per providers orders HHC [home health care] is able to complete twice weekly during approved SN visits …" The plan of care dated 02/07/2025 contained wound care orders, to be performed to four (4) sites: wound #1 - left 3rd toe, wound #2 - left 2nd toe, wound #3 - left medial great toe, and wound #4 - right heel. The Plan of Care failed to evidence the addition of a fifth wound (to the left lateral foot) on 02/18/2025, and failed to evidence corresponding wound care orders to the site. Further review of the clinical record contained serial nursing visit notes dated: 02/21/2025, 02/24/2025, 02/27/2025, 03/03/2025, and 03/06/2025 which evidenced wound care had been provided to wounds #1 - #4, and failed to evidence physician ordered wound care had been provided to the left lateral foot (wound #5). 3. On 03/12/2025 at 9:06 AM, Registered Nurse (RN) 1 confirmed had been providing care for Patient #13 and indicated had been caring for, "four wounds … well, four and a half", and had also provided wound care to the newest site, the left lateral foot (wound #5). RN 1 indicated this was really more "protection" to the site, but realized care provided to the additional site had not been documented in the skilled nursing visit notes.	G0580		

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G0580	Continued from page 6 On 03/12/2025 at 10:41 AM, the Administrator indicated would have liked to have seen the additional order for the left lateral wound and the subsequent care provided to Patient #13 had been documented. 410 IAC 17-13-1(a)	G0580		
G0590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This ELEMENT is NOT MET as evidenced by: Based on record review and interviews, the agency failed to notify the physician of a change in condition for 1 of 2 active clinical records reviewed, of patients who received Occupational and Speech therapy. Findings Include: 1. A review of an agency policy dated October 2024 and titled 'Patient Clinical Records', indicated but was not limited to, "… Agency professional staff promptly alerts the physician of any changes in patient condition that suggest a need to alter the plan of care …" 2. A review of agency policy dated August 1, 2017, and titled 'Care Coordination', indicated but was not limited to, "… The RN or Therapist continually assess the client's condition … and communicates to the physician and all members of the health care team …" 3. A review of agency policy updated 08/01/2022 and titled 'Clinical Record Documentation', indicated but was not limited to, " … Progress note communication includes … Contact with physician … Contact with any interdisciplinary team member …" 4. Review of the clinical record for Patient #10 revealed a Physical Therapy Aide (PTA) missed visit on 02/27/2025. Patient #10 went to the Emergency Room (ER) for a transient unconscious episode (a loss of	G0590		

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G0590	Continued from page 7 unconsciousness with complete recovery) and returned to the Assisted Living Facility (ALF), where the patient resided, the same day. 5. Review of the clinical record for Patient #10 revealed an agency document titled 'Missed Visit' dated 02/27/2025, "PTA Visit," indicated the physician was not notified of the change in the Patient's condition and ER visit. 6. During a phone interview with PTA #3 on 03/11/2025 at 12:27 PM, he/she confirmed a missed PTA visit on 02/27/2024, as Patient #10 was at the hospital. They indicated Woodland Terrace Assisted Living staff was present during the episode and sent Patient # 10 to the ER. PTA #3 indicated they did not notify the physician. 7. In an interview with Administrator on 03/11/2025 at 1:37 PM, she indicated the agency did not notify the physician of the missed visit on 02/27/2025. During a conversation the Administrator had with PTA #3, the PTA indicated they thought the ALF had notified the physician of the change in condition and missed PTA visit. 410 IAC 17-13-1(a)(2)	G0590		
G0598	Discharge plans communication CFR(s): 484.60(c)(3)(ii) (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure revisions related to plans for discharge were communicated to the patient and/or the patient's representative in 1 of 3 active clinical records reviewed who received Physical Therapy and Skilled Nursing Services. (Patient #14)	G0598		

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G0598	Continued from page 8 Findings include: 1. A review of a policy titled Patient/Client Discharge Policy Number 217 stated, "… Discharge Criteria: 1. Criteria for discharge may include, but not limited to the following … e. The contracting payer terminates authorization for service … 7. Provide patient with the Notice of Medicare Non-Coverage (NOMNC), if applicable … b. The NOMNC must be delivered at least 2 calendar days before Medicare covered services end … c. The NOMNC should be signed and dated to demonstrate that the beneficiary or representative received the notice … d. If beneficiary is incapable or incompetent … the Agency shall telephone the representative through personal contact … to advise him or her when the beneficiary's services are no longer covered … 9. To avoid charges of "abandonment" at the time of discharge agency documentation will include the following: a. Evidence that the decision was not made unilaterally. The client, family and physician participated in the decision to discharge … b. Evidence that the client … there is no payer source for ongoing services c. If there are unmet needs and the agency is no longer able to meet those needs, documentation will demonstrate … notice was given and referrals made …" 2. A review of the clinical record for Patient #14 evidenced a PT Plan of Care dated 01/20/2025, signed by PT 4 indicated Treatment Plan was to be 2 times a week for 5 weeks for but not limited to Therapeutic exercise, balance training, and establish/upgrade home exercise program. Further review of the clinical record for Patient #14 evidenced PT visits occurred on 01/20/2025, 01/22/2026, and 01/27/2025 and a PT discharge dated 01/31/2025 signed by PT 4, which indicated reason for discharge was "Insurance". The record failed to evidence MD, Patient or the Patient's representative notification of PT discharge. 3. On 03/11/2025 at 10:53 AM, PT 4 indicated patients would be discharged if there was no reimbursement from the insurance company, but not sure how the agency should handle it. On 03/11/2025 at 1:25 PM during an interview with the Administrator, they indicated utilizing insurance	G0598		

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G0598	Continued from page 9 companies can be a challenge, but the agency must notify the patient or the Patient's representative along with the MD of a discharge due to services no longer being covered, and all communications must be documented.	G0598		