STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K152	A. BUILDING B. WING	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEAM SELECT HOME CARE	5614 INDUSTRIAL ROAD, FORT WAYNE, IN, 46825

(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 6, 7, 10, and 11, 2025 Active Census: 97 At this Emergency Preparedness survey, Team Select Home Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider.	G0000		

	Survey Dates: March 6, 7, 10, and 11, 2025 12-Month Unduplicated Skilled Admissions: 23 Partially extended on 03/07/2025 at 4:35 PM. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Abbreviations: RN Registered Nurse POC Plan of Care CM Clinical Manager SOC Start of Care SN Skilled Nurse QR 3/13/25 A2			
G0436	Receive all services in plan of care 484.50(c)(5) Receive all services outlined in the plan of care. Based on record review and interview, the home health agency failed to ensure patients received all services as ordered in the POC for 2 of 5 active patient records	G0436	The clinical records for patients #2 and #4 have been updated to properly reflect the services provided, and information regarding the missed visits has been reported to the physician. All internal staff members have been re-educated on 3/10/25 regarding the requirement to adhere to the physician-ordered frequency and duration. All	2025-03-26

	reviewed (Patient #2, 4). Findings include: 1.The Visit Schedule / Missed Visit policy, revised 06/25/2024, indicated "In the event of employee illness, vacation, holidays and unexpected voluntary or involuntary termination of employment, the Agency will provide alternate, qualified personal care worker(s) to complete the required visits... The Agency will coordinate with the patient or patient's authorized representative to reschedule a missed visit whenever possible..." 2. Review of Patient #4's clinical record included a SOC date of 03/11/2020, a POC for certification period 12/15/2024 to 02/12/2024 with orders including but not limited to SN visits four to six days per week, and a POC for certification period 02/13/2025 to 04/13/2025 with orders including but not limited to SN visits four to six days per week. Review of Patient #4's SN visit notes indicated Patient #4 received two SN visits the week of 01/05/2025 and three SN visits the weeks of 01/12/2025,		internal staff members have been re-educated on 3/26/2025 on the requirement to initiate a case conference for repeated declination of service or staffing inconsistencies and to obtain orders from the patient's physician if the patient requests schedule changes, or assist the patient with identifying a new agency if Team Select is unable to meet the patient's staffing needs.. The Administrator and DON will ensure this education is provided to all incoming internal staff members during the orientation and training process.The Administrator will audit the visit schedule weekly for 60 days, beginning 3/25/2025, to ensure 100% compliance with these requirements. The DON will review schedule worked against ordered F&D during the 10% quarterly clinical record audit as part of the Agency's QAPI program to ensure continued compliance.The Administrator is responsible for monitoring these corrective actions to ensure the deficiency is correctedand will not recur.Completed 3/26/25	

	01/19/2025, 01/26/2025, 02/02/2025, 02/09/2025, 02/16/2025, and 02/23/2025. Patient #4 received no SN visits the week of 03/02/2025. Missed visits notes indicated a reason of "Caregiver Cancelled" for missed visits on 01/09/2025, 01/10/2025, 01/16/2025, 01/17/2025, 01/23/2025, 01/24/2025, 01/30/2025, 01/31/2025, 02/06/2025, 02/07/2025, 02/13/2025, 02/14/2025, 02/20/2025, and 02/21/2025. The agency failed to ensure Patient #4 received SN visits four to six times per week any week from 01/05/2025 through 03/07/2025. During an interview on 03/07/2025 at 4:11 PM, the CM indicated she was Patient #4's RN case manager and indicated "caregiver cancelled" meant the agency employee cancelled the visit. The CM further indicated Patient #4 did not receive their SN frequency as ordered in the POC due to the following missed visits which were all documented as "caregiver cancelled": 01/06/2025,			

	01/16/2025, 01/17/2025, 01/23/2025, 01/24/2025, 01/30/2025, 01/31/2025, 02/06/2025, 02/07/2025, 02/13/2025, 02/20/2025, and 02/21/2025. The CM indicated the missed visit documentation was not yet there for the missed SN visits on 02/27/2025, 02/28/2025, 03/03/2025, 03/04/2025, 03/05/2025, 03/06/2025, and 03/07/2025. During an interview on 03/07/2025 at 4:18 PM, the Administrator indicated the reason there were no SN visits the week of 03/02/2025 was because the regular nurse had surgery, and another nurse is in training that will provide services to that patient. 3. Review of Patient #2's clinical record included a SOC date of 11/28/2023 and a POC for certification period 01/21/2025 to 03/21/2025 with orders for SN visits, one to two visits, five to seven days per week. Review of Patient #2's SN visit notes indicated the patient received four SN visits the week of 02/16/2024. Missed visit notes indicated the reason for the missed visit on			

	02/16/2025 was "Caregiver Cancelled." During an interview on 03/11/2025 at 11:45 AM, the Alternate CM indicated she was Patient #2's RN case manager. The Alternate CM further indicated the reasons Patient #2 did not receive their SN frequency as ordered in the POC for the week of 02/16/2025 through 02/22/2025 were the nurse called off sick for the 02/16/2025 shift, and the agency was unable to find a replacement. The Alternate CM indicated on 02/17/2025 it looked like the nurse was unavailable and indicated for the 02/21/2025 visit a member of the patient's family cancelled the visit because they were going to be with the patient and would provide care.			
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, record	G0682	All Agency employees, including RN #2, were re-educated on infection control precautions, including bag technique, on 3/7/2025 and 3/31/2025. All incoming direct-care employees will continue to receive this education during the orientation and training process, prior to the provision	2025-03-31

	review, and interview, the home health agency failed to ensure infection control precautions were performed related to bag technique for 1 of 2 home visit observations of RNs (RN 2). Findings include: 1 .The Exposure Control Plan: OSHA Regulations policy, revised 06/25/2024, indicated "...Nursing Bag Technique... Upon entering the home, place the bag on a clean surface; paper towels, barriers or plastic bag must be used to create a clean area..." 2. A home visit observation of RN 2 providing care for Patient #3 was conducted on 03/07/25 beginning at 9:33 AM. Observed RN 2's nurse bag open and directly on floor with no barrier underneath. 3. During an interview on 03/07/2025 at 10:00, RN 2 indicated that the area the bag was located on the floor was the designated area for his bag in the patient's home. 4. During an interview on 03/07/2025 at 4:23 PM, the CM indicated the nurse bag should not be left open in the patient's home when not being accessed		of patient care.Supervising RNs will observe field employees' adherence to infection precautions during in-home supervisory andrecertification visits on an ongoing basis, beginning 3/24/2025, and this observation will be documented in the supervisory component of each patient assessment. Every employee performing patient care will have an annual infection control competency assessment conducted by an RN to ensure employees remain compliant with practicing proper infection control measures. This competency assessment will be evidenced in each employee's file.The DON is responsible for monitoring these correctiveactions to ensure the deficiency is corrected and will notrecur.Completed 3/31/25	

	and indicated the nurse bag should not be placed directly on the floor. The CM further indicated the nurse bag should be placed on barrier or hung from a chair.			
N0000	Initial Comments This visit was for a State Re-Licensure survey of a Home Health Provider. Survey Dates: March 6, 7, 10, and 11, 2025 12-Month Unduplicated Skilled Admissions: 23 Abbreviations: CM Clinical Manager HHA Home Health Aide	N0000		
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure,	N0458	The Alternate Clinical Manager has signed a new job description on 3/11/2025 and has completed an orientation checklist on 3/20/2025, for her role asAlternate Clinical Manager. These documents have been added to the	2025-03-27

	certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of an employee's national/expanded criminal history background check pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the home health agency failed to ensure the Alternate CM's personnel file included a job description and orientation to that role for 1 of 1 Alternate CM. Findings include: 1. The Personnel Records policy, dated 02/12/2023, indicated "The personnel record for an employee will include... Signed copy of job description... Validation of completion of the orientation process with		employee's personnel record. All employees responsible for managing personnel records have been re-educated on 3/27/25 regarding the requirement to have a job description and proof of orientation for all positions held.The Administrator reviewed the personnel records for 50% of employees hired within the last 12 months, and all records are compliant with the above requirement.The Administrator will review 100% of personnel records for newly hired employees for 60 days to ensure ongoing compliance with the requirement to have a position-specific job description and documented orientation.The Administrator is responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.Completed 3/27/25	

	checklist…" 2. Review of the Alternate CM's personnel record failed to include a job description and orientation checklist for her role as Alternate CM. 3. During an interview on 03/11/2025 at 1:17 PM, the Administrator indicated the Alternate CM's personnel record did not include a job description and orientation checklist for the role of Alternate CM.			
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.	N0464	All Agency employees responsible for hiring and onboarding new employees have been re-educated on the Agency's TB policy on 3/11/2025 and 3/27/2025, including the requirement that any TB test administered prior to hire date must also be read prior to hire date, not just prior to the first day of patient contact.The Administrator has reviewed the personnel records for 50% of employees hired within the last 12 months, and all records are compliant with the above requirements.The Administrator will review the personnel files for 100% of all	2025-03-31

	(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on record review and interview, the home health agency		newly hired employees for 60 days to ensure that the initial TB testing and screening process is conducted in accordance with the Agency's TB policy. The Administrator will include a review of initial and annual TB records during the quarterly 10% personnel audit as part of the Agency's QAPI program.The Administrator is responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.Completed 3/31/25	

failed to ensure all staff were screened for tuberculosis per their policy for 1 of 6 HHA personnel records reviewed (HHA 1).

Findings include:

1 .The Health Screening policy, dated 12/30/2021, indicated "...Any employee providing care to Agency patients with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay, unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) month period and the result was negative..."

2. The Personnel Records policy, dated 02/12/2023, indicated "...The personnel record for an employee will include... TB Screening Documents... Documentation of a 2-step tuberculin skin test performed upon hire with documentation showing the first step was completed prior to providing patient services and second step completed within 1-3 weeks of first step..."

	3. HHA 1's personnel record included documentation of a tuberculin skin test administered on 04/25/2023, the same date as her hire date. HHA 1's personnel record failed to include a second tuberculin skin test within one to three weeks of the first step. 4. During an interview on 03/11/2025 at 1:17 PM, the Administrator indicated HHA 1 should have had a second tuberculin skin test unless there was documentation of a tuberculin skin test before the one that was documented as administered on 04/25/2023.			

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
Jon Rocholl	Administrator	3/31/2025 3:09:20 PM