STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157592	A. BUILDING B. WING	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LMR Indiana Home Health Inc	1563 E 85th Avenue, MERRILLVILLE, IN, 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR §484.102 Survey Dates : May 20, May 21, and 22, 2025 Active Census: 73 At this Emergency Preparedness survey, LMR Indiana Home Health INC, was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR §484.102.	E0000	Initial Comments	
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State	G0000	Initial Comments	

	Re-Licensure survey of a home health provider. Survey Dates: May 19, 20, 21, and 22, 2025 Unduplicated 12 month skilled admissions: 190 A partially extended survey was announced to the Administrator on 05/20/2025 at 5:03 PM. An extended survey was announced to the Administrator on 05/22/2025 at 12:50 PM. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. During this Federal Recertification Survey, LMR Indiana Home Care, Inc. was found to be out of compliance with Condition of Participation 42 CFR 484.60 Care planning, coordination of services, and quality of care. Based on the Condition-level deficiencies during the 05/22/2025 survey, your agency was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social			

	Security Act on 05/22/2025. 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 05/22/2025 and continuing through 05/21/2027. Abbreviations used in report: Home Health Aide [HHA], Clinical Supervisor [CS], Registered Nurse [RN], Plan of Care [POC], Start of Care [SOC], Occupational Therapist [OT], Skilled Nurse [SN], and Physical Therapist [PT]. QR: A1 5/29/2025			
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and	G0514	1. Patient charts were audited to check referral dates and SOC comprehensive dates. Referral log is utilized to ensure timely SOCs by office scheduling team. Education was given to the office and clinical team as to the importance of communication to physicians and documentation of any delay in care orders received. 2. Patient charts are reviewed in conjunction with the daily referral log to ensure a SOC is completed within 48 hours of referral. Any delays or patient requests are documented and a delay in care order is received by certifying physician. 3. Reviewed P&Ps relating to timely SOC requirements with Clinical, Office and QA staff. Held multiple in-services with the Clinicians, Office and QA team regarding the need to	2025-06-16

	interview, the agency failed to conduct the initial assessment within 48 hours from the referral in 2 of 5 active clinical records reviewed. (Patient #1, 2) The findings include: 1. A clinical record review for Patient #1 evidenced the referral for home health from Entity 2 dated 04/11/2025. The SOC comprehensive assessment indicated the referral date and the Patient s discharge date from Entity 2 were 04/11/2025 and indicated the date of the assessment was 04/14/2025. A communication note dated 04/14/2025 completed by the CM indicated the Patient requested a SOC on 04/14/2025 and indicated the physician was notified of the delay in the SOC. On 05/22/2025, at 11:25 AM, the CM indicated there was no other documentation prior to 04/14/2025 regarding the delay in the SOC. 2. A clinical record review for Patient #2 evidenced the referral for home health from Entity 2 dated 05/16/2025. The SOC comprehensive assessment indicated the referral date and		ensure the comprehensive assessment occurs within 24-48 hours of referral. 4. The Clinical Supervisor with the assistance of the Office Manager will track the referral log sheet and ensure any delays in care are documented in the chart and an appropriate verbal order is obtained from the physician. 100% of new referrals will be audited daily to ensure adherence to company policy and regulatory requirements.	

	the Patient s discharge date from Entity 2 were 05/16/2025 and indicated the date of the assessment was 05/19/2025. A communication note dated 05/19/2025 completed by the CM indicated a delay in the SOC due to a scheduling issue. On 05/22/2025, at 11:53 AM, the CM indicated the initial visit was scheduled for 05/17/2025, but the agency had the wrong address for the Patient and by the time the correct address was identified, the SN was no longer available to complete the initial assessment and was not available on 05/18/2025. 3. On 05/19/2025, beginning at 3:20 PM, the CM indicated the initial visit assessment was conducted at the same time as the SOC comprehensive assessment.			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: (1) The patient's current health, psychosocial,	G0528	1. Patient charts were audited and addendum orders to the POC were created to correct noted deficiencies and ensure accurate information. Education was given to the clinical team as to prevent future occurrences. 2. Patient charts that included a diagnosis of diabetes were audited and updated to include the frequency of blood sugar checks and whom is doing the checks. Visit notes were audited to ensure an accurate pain assessment on every visit. 3. Reviewed P&Ps relating to the	2025-06-16

	functional, and cognitive status; Based on record review and interview, the agency failed to ensure the comprehensive assessment included the current health and functional status in 1 of 2 active clinical records reviewed with a SOC within 45 days of survey (Patient #1). The findings include: 1. A policy titled Pain Assessment and Reassessment revised February 2024 indicated the pain assessment will include the location, intensity, duration, and character of the pain. 2. A clinical record review for Patient #1 evidenced a SOC comprehensive assessment dated 04/14/2025 which indicated the Patient was diabetic (a chronic disease that affects the blood sugar) and indicated the parameters for when the Patient was to notify the physician for high or low blood sugar. The comprehensive assessment failed to include the frequency of blood sugar checks. The comprehensive assessment indicated the Patient had pain occasionally that affected sleep, therapy activities, and day-to-day activities and failed		comprehensive assessment and required pain assessments with Clinical and QA staff. Held multiple in-services with the Clinicians and QA team regarding the need to ensure the comprehensive assessment includes the current health and functional status of the patient specifically addressing a complete pain assessment and the frequency of blood sugar checks. 4. The Clinical Supervisor with the assistance of the QA team will audit all OASIS E-1 SOCs, ROCs and Recerts for completeness before approval. The Clinical Supervisor and the QA team will audit all completed Plan of Cares with an audit form to ensure completeness and accuracy. 100% of new Plan of Cares will be audited for a minimum period of 90 days or until a 95% accuracy rate for comprehension and accuracy is achieved. The QA team will review all clinician notes before approval to ensure the POC is followed precisely and all care is provided only as ordered by physician. This will continue indefinitely.	

	to include the location, intensity, and character of the pain. On 05/22/2025, at 11:33 AM, the CM indicated the comprehensive assessment did not include the complete pain assessment and the frequency of the blood sugar checks. 410 IAC 17-14-1(a)(1)(A)			
G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on record review and interview, the agency failed to ensure the comprehensive assessment included the caregiver s ability, availability, and willingness to provide care in 1 of 2 active clinical records reviewed which indicated the patient resided with a caregiver and day 5 of the comprehensive assessment had passed. (Patient #1) The findings include: Clinical record review for Patient #1 evidenced a SOC	G0538	1. Patient charts were audited and addendum orders to the POC were created to correct noted deficiency and ensure accurate information. Education was given to the clinical team as to prevent future occurrences. 2. Patient charts that included a diagnosis of a wound were audited and updated to include the frequency of wound care, whom is doing the care and the caregiver's ability, availability, and willingness to provide care. 3. Reviewed P&Ps relating to the comprehensive assessment and wound documentation with Clinical and QA staff. Held multiple in-services with the Clinicians and QA team regarding the need to ensure the comprehensive assessment includes the current health and functional status of the patient specifically addressing how often, by whom and their ability, availability and willingness to provide wound care. 4. The Clinical Supervisor with the assistance of the QA team will audit all completed POCs for completeness and accuracy. A QA audit form will be utilized to ensure a comprehensive POC order will be sent to the physician 100% of new Plan of Cares will be audited for a minimum period of 90 days or until a 95% accuracy rate for comprehension and accuracy is achieved.	2025-06-16

	comprehensive assessment dated 04/14/2025 which indicated the Patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) Stage III (an open pressure ulcer with full thickness loss of skin) to the sacrum (lower back). The POC for the initial certification period 04/14/2025-06/12/2025 indicated the Patient required wound care 3 times a week, and the agency would provide SN services 2 times a week for 4 weeks and then 1 time a week for 4 weeks. The comprehensive assessment indicated the Patient required assistance for personal care, feeding, and medication administration and indicated the Patient was incontinent of bladder and was a diabetic (having a chronic disease affecting blood sugar) requiring blood sugar monitoring. The comprehensive assessment indicated the Patient lived with someone around the clock but failed to include the assessment of the caregiver s ability, availability, and willingness to provide wound care, blood sugar monitoring, medication administration, and personal			

	care. On 05/22/2025, at 11:36 AM, the CM indicated the comprehensive assessment did not indicate who was providing wound care in the absence of the SN and did not specifically indicate if the caregiver was willing and able to provide personal care, blood sugar checks, and medication administration.			

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 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 record review and interview, the home health agency failed to ensure: the patient s needs were met (See tag G0570); services were provided per the plan of care (See tag G0572); the plan of care included all required information / elements for the treatment of the patient (See tag G0574); services were provided only as ordered by a physician (See tag G0580); verbal orders were written and authenticated (See tag G0584); physicians were promptly notified of a change in the patient's condition (See tag G0590); communication with all physicians involved in the plan of care (See	G0570	1. Patient charts were audited and addendum orders to the POC were created to correct noted deficiencies and ensure accurate information. Charts were audited to ensure that we can meet the patient's medical, nursing, rehabilitative, and social needs in their place of residence. Patient plan of cares were audited to include all necessary elements as per company policy and regulatory requirements. Patient charts that included a diagnosis of diabetes were audited and updated to include the frequency of blood sugar checks and whom is doing the checks. Patient charts that included a diagnosis of a wound were audited and updated to include the frequency of wound care, whom is doing the care and the caregiver's ability, availability, and willingness to provide care. Patient charts were reviewed to ensure all orders, including what disciplines were ordered and how frequently to be seen were followed. Patient charts were audited to identify if the physician needed to be alerted of any significant changes to patient condition or needs not being met by the agency. If it was identified that we were struggling to meet a patient's needs the doctor was consulted and a plan was put into place to address the issue up to and including transferring the patient to another agency that can better service the patient. Education was given to the clinical team as to prevent future occurrences. 2. Patient charts were reviewed to ensure each patient has a individualized plan of care that specifies the care and services necessary to meet patient specific needs as identified in the comprehensive assessment. 3. Reviewed P&Ps relating to the comprehensive assessment, POC accuracy and specificity, timely SOCs, missed visits, following MD orders, verbal order requirements, MD notification when there is a change in condition, ensuring communication with the MD and coordinating care with all members of the care team with the Clinical and QA staff. Held multiple in-services with the Clinicians, Office and QA team regarding topics noted. The clinical team expressed understanding of material discussed and asked appropriate questions for needed clarification. 4. The Clinical Supervisor with the assistance	2025-06-16

	care for all services provided to the patient (See tag G0606). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.60 Care Planning, Coordination of Care and Quality of Care. A deficient practice citation was also evidenced at this standard as follows: Based on observation, record review, and interview, the agency failed to meet the needs of the patients in 2 of 5 active clinical records reviewed (Patient #2, 5) and in 2 of 2 closed clinical records reviewed (Patient 6, 7). The findings include: Based on record review and interview, the home health agency failed to ensure: the patient s needs were met (See tag G0570); services were provided per the plan of care (See tag G0572); the plan of care included all required information / elements for the treatment of the patient (See tag G0574); services were provided only as ordered by a physician (See tag G0580); verbal orders were written and authenticated (See tag G0584); physicians were promptly		of the QA team will audit all OASIS E-1 SOCs, ROCs and Recerts for completeness before approval. The Clinical Supervisor and the QA team will audit all completed Plan of Cares with an audit form to ensure completeness and accuracy. 100% of new Plan of Cares will be audited for a minimum period of 90 days or until a 95% accuracy rate for comprehension and accuracy is achieved. 100% of all clinical documentation will be reviewed by Clinical Supervisor and QA team until further notice.	

notified of a change in the patient's condition (See tag G0590); communication with all physicians involved in the plan of care (See tag G0602); and coordination of care for all services provided to the patient (See tag G0606).

The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.60 Care Planning, Coordination of Care and Quality of Care.

A deficient practice citation was also evidenced at this standard as follows:

Based on observation, record review, and interview, the agency failed to meet the needs of the patients in 1 of 5 active clinical records reviewed (Patient #2) and in 2 of 2 closed clinical records reviewed (Patient 6, 7).

The findings include:

1. A clinical record review for Patient #2 evidenced a SOC comprehensive assessment dated 05/19/2025 which indicated the Patient required assistance with personal care, activities of daily living (ADLs), and feeding and lived at home with a caregiver. The record failed to identify if the caregiver was willing and able to provide the required care and failed to evidence the agency inquired if the Patient would be interested in HHA services to assist with care.

During an observation of care at the Patient s home on 05/20/2025, beginning at 11:53 AM with the PT, the Patient was observed requiring assistance with sit-to-stand transfers, ambulation with short distances, and wheelchair mobility.

On 05/20/2025, at 2:28 PM, the Patient s caregiver indicated they were 71 years old, had open heart surgery, and indicated it was physically taxing to provide personal care and assist with ADLs. The Patient s caregiver indicated the CM informed the Patient the

agency would be providing a HHA to assist in a week or so.

At the entrance conference on 05/19/2025, beginning at 3:20 PM, the CM indicated the agency provided HHA services but currently had no HHA and did not have a contract with another agency to provide HHA services. The CM indicated the agency was trying to hire HHAs to provide HHA services.

On 05/21/2025, at 9:40 AM, the CM indicated the last date the agency provided HHA services was in December 2023 and had no employed HHA since then.

On 05/20/2025, at 3:30 PM, the CM indicated she did inform the Patient s caregiver the agency would be able to provide a HHA soon and indicated she thought the agency would have a HHA hired and ready to staff the Patient in a couple of weeks. The CM indicated she did not refer the Patient to another agency that could provide a HHA immediately.

2. A clinical record review for Patient #6 evidenced a SOC order dated 03/31/2025 signed

	by the physician and the POC for the initial certification period 03/31/2025-05/29/2025 which indicated the home health services were to include OT services. The discharge comprehensive assessment dated 04/24/2025 indicated the Patient required assistance with personal care to include dressing, grooming, bathing, and toilet hygiene. The clinical record failed to evidence the agency provided OT services. On 05/22/2025, at 12:22 PM, the CM indicated she was unsure why OT services were not provided and indicated there was no documentation regarding why OT services were not provided. 3. A clinical record review for Patient #7 evidenced a SOC order dated 03/26/2025 signed by the physician which indicated the home health services were to include OT, and a POC for the initial certification period 03/26/2025-05/24/2025 indicated the services the agency was to provide included ST services. The Face to Face signed by the physician and dated 04/03/2025 indicated OT			

	medically necessary and were to be provided by the home health agency. The SOC comprehensive assessment dated 03/26/2025 indicated the Patient had a recent hospitalization for aspiration-related pneumonia (when difficulty swallowing causes food/fluid to be inhaled into the lungs) and had a gastrostomy tube (feeding tube) inserted due to aspirating when eating. The SOC comprehensive assessment indicated ST was to evaluate and treat, but the clinical record failed to evidence ST services were provided. The DC comprehensive assessment dated 04/23/2025 indicated the Patient required assistance for personal care to include grooming, dressing, and bathing. The clinical record failed to evidence the agency provided OT and HHA services. On 05/22/2025, beginning at 12:39 PM, the CM indicated the agency did not provide OT, ST, and HHA services, and there was no documentation on why the services weren t provided.			

	410 IAC 17-13-1(a) 1. A revised policy, dated February 2024, titled, Coordination of Patient Care, indicated the agency must integrate services whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and provide coordination of care by all disciplines. 2. A revised policy, dated February 2024, titled, Care Planning Process, indicated the plan of care would demonstrate problems and interventions through physician orders, and all patient care orders, including verbal orders, would be recorded in the plan of care. 3. A Comprehensive Assessment, dated 03/08/2025, indicated Patient #5 had a diagnosis of a cerebral vascular accident [CVA] (stroke) with hemiplegia (one side of the body paralysis or weakness) affecting the left nondominated side. The comprehensive assessment indicated Patient required someone to assist the			

	patient to put on undergarments, slacks, socks, and shoes, the patient was able to participate in bathing self in shower or tub but required presence of another person throughout the bath for assistance or supervision, someone must help the patient to maintain toileting hygiene or adjust clothing, the patient was able to bear weight and pivot during the transfer process but unable to transfer self, the patient was unable to feed themselves and would require assistance or supervision throughout the meal, required partial/moderate assistance for oral hygiene, toileting hygiene, and substantial/maximal assistance for shower/bath. A Face to Face Encounter dated 03/14/2025, indicated physician signing was the plan of care certifying physician and based on the clinical findings the patient required home services of occupational therapy. A clinical record review, on 05/21/2025, failed to evidence Patient received occupational therapy. During an interview, on 05/22/2025, beginning at 1:00			

	PM, the Administrator indicated Patient did not receive occupational therapy and Patient was ordered to have occupational therapy. An order from physician 4, dated 03/07/2025, indicated Patient may be discharged to entity, 1, a nursing facility with home health services. A clinical record review on 05/22/2025, failed to evidence the agency offered a home health aide to Patient. During an interview, on 05/21/2025, beginning at 4:20 PM, Registered Nurse [RN] 2 indicated a home health aide was not offered to Patient due to Patient resided in an assisted living facility that provided care and the assisted living facility would provide care besides giving a bath such as assisting Patient to bed. During an interview, on 05/22/2025, beginning at 1:00 PM, entity 1, a nursing facility indicated Patient resided in the independent living facility and had a service agreement to pay for extra care which included showers 2 times per week, AM and PM dressing and grooming,			

	and incontinent care one time per day. 410 IAC 17-13-1(a)			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure the POC was developed in conjunction with the physician and the services were provided as ordered by the physician and in the POC in 2 of 4 active clinical records reviewed which received skilled services for more than 6 days. (Patient #1 and 5) The findings include:	G0572	1. Patient charts were audited and addendum orders to the POC were created to correct noted deficiency and ensure accurate information. Missed visits were reviewed to ensure completeness and documentation of physician notification. Education was given to the clinical team as to prevent future occurrences. 2. Patient charts were reviewed to ensure the POC was developed in conjunction with the physician and the services were provided as ordered by the physician. Reports on any missed visits were run and followed up upon to ensure proper documentation was completed and the physician was notified. 3. Reviewed P&Ps relating to missed visits with Clinical team. Held multiple in-services with the Clinicians and QA team regarding the need to follow ordered frequencies and to notify physician immediately of any missed visits. Education was given on discussing the POC, following doctor's orders and communicating regularly with the physician. 4. The Clinical Supervisor and the QA team will audit all completed Plan of Cares with an audit form to ensure completeness and accuracy. The audit will include the SOC order and POC review with the singing physician. 100% of new Plan of Cares will be audited for a minimum period of 90 days or until a 95% accuracy rate for comprehension and accuracy is achieved. Missed visit reports will be run weekly by the Clinical Supervisor to ensure all visits have been accounted for and all doctors have been notified of any missed visits. This	2025-06-16

	1. A clinical record review for Patient #1 evidenced a SOC comprehensive assessment completed by RN 1 dated 04/14/2025 which failed to evidence the RN coordinated care and reviewed the POC with the physician, and the clinical record failed to evidence documentation the POC was reviewed with the physician. The POC for the initial certification period 04/14/2025-06/12/2025 signed by RN 1 was not yet signed by the physician, and the activity tracking for the electronic health record indicated the POC had not yet been sent to the physician. The POC indicated the primary diagnosis was chronic and acute respiratory failure and indicated the Patient received oxygen continuously at 3 liters per minute (lpm). The POC indicated the SN was to assess the respiratory status and administer oxygen at 3 lpm continuously. The SN visit notes completed by LPN 1 dated 04/18/2025, 04/21/2024, 04/25/2025, and 05/11/2025 indicated the Patient was on room air and failed to indicate the SN provided the services per the POC to include administration of oxygen at 3		will continue indefinitely.	

	lpm. On 05/22/2025, beginning at 11:29 AM, the CM indicated there was a delay in sending the POC to the physician due to quality assurance (QA), the SOC comprehensive assessment did not indicate the RN discussed the POC with the physician, and there was no documentation the agency discussed the POC with the physician. The CM indicated the oxygen administration was not included on the SN visit notes by LPN 1 for the dates listed above. 2. A clinical record review for Patient #2 evidenced a SOC comprehensive assessment completed by RN 1 dated 05/19/2025 which failed to evidence the RN coordinated care and reviewed the POC with the physician, and the clinical record failed to evidence documentation the POC was reviewed with the physician. The POC for the initial certification period 05/19/2025-07/17/2025 signed by RN 1 was not yet signed by the physician. On 05/22/2025, at 10:49 AM, RN 1 indicated the physician responsible for the POC was on			

vacation and had not yet talked to the physician on-call.

On 05/22/2025, at 12:03 PM, the CM indicated she had spoken to the physician on-call on 05/21/2025 but only discussed the drug interactions and not the POC.

3. On 05/22/2025, beginning at 10:49 AM, RN 1 indicated 9 out of 10 times, she did not speak to the physician responsible for the POC and would leave a message regarding the SOC. RN 1 indicated usually the POC was signed and returned by the physician before ever hearing back from the physician.

410 IAC 17-13-1(a)

A revised policy, dated February 2024, titled, Plan of Care-CMS #485 and Physician/Practitioners Orders, indicated if the agency missed a visit or a treatment as required by the plan of care, which results in any potential for clinical impact upon the patient, then the agency must notify the responsible physician of such

	sed treatment or service. 2. A Plan of Care, for certification period 05/07/2025 to 07/05/2025, for Patient #5 indicated skilled nursing visits 1 time per week. A Clinical record review failed to evidence a skilled nurse visit for the week of 04/27/2025 to 05/04/2025. The clinical record failed to evidence the physician was notified or the missed visit was rescheduled. The clinical record indicated a skilled nursing visit on 04/17/2025 and the next skilled nursing visit was on 05/05/2025. The Plan of Care indicated the skilled nurse was to perform pressure ulcer care to the left heel due to Patient was unable to reach foot to change the dressing and Patient had no other reliable caregivers available. During an interview, on 05/22/2025, beginning at 1:00 PM, the Administrator, Administrative Staff 1 indicated there was a missed skilled nurse s visit the week of 04/27/2025, indicated the agency s work week was scheduled Sunday to Saturday and the clinical record			

	did not contain documentation of the reason for the missed skilled nurse visit. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (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	G0574	1. Patient charts were audited and addendum orders to the POC were created to correct noted deficiency and ensure accurate information. Education was given to the clinical team as to prevent future occurrences. 2. Patient charts that included a diagnosis of diabetes were audited and updated to include the frequency of blood sugar checks and whom is doing the checks. Patient charts that included a diagnosis of a wound were audited and updated to include the frequency of wound care, whom is doing the care and the caregiver's ability, availability, and willingness to provide care. 3. Reviewed P&Ps relating to the comprehensive assessment with Clinical and QA staff. Held multiple in-services with the Clinicians and QA team regarding the need to ensure the comprehensive assessment includes the current health and functional status of the patient specifically addressing the frequency of blood sugar checks for diabetic patients, the appropriateness of wound care clarification, the need for medication management and reconciliation on every visit and any interventions ordered by the physician such as specialty nutritional supplements. 4. The Clinical Supervisor and the QA team will audit all completed Plan of Cares with an audit form to ensure completeness and accuracy. Specific note to diabetic and wound care patients to include required information. 100% of new Plan of Cares will be audited for a minimum period of 90 days or until a 95% accuracy rate for comprehension and accuracy is achieved.	2025-06-16

identified by the HHA and the patient;

(xv) Information related to any advanced directives; and

(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.

Based on observation, record review, and interview, the agency failed to ensure the plan of care included all patients medications and treatments in 4 of 4 active clinical records reviewed receiving skilled services for more than 6 days (Patient # 1, 3, 4, and 5).

Findings include:

And 2 of 2 closed clinical records reviewed (Patient #6, 7)

1. A clinical record review for Patient #1 evidenced a SOC comprehensive assessment dated 04/14/2025 which indicated the Patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) Stage III (an open pressure ulcer with full thickness loss of skin) to the sacrum (lower back). The SOC comprehensive assessment indicated the Patient had a diagnosis of diabetes (a chronic disease that affects the blood

	sugar). The POC for the initial certification period 04/14/2025-06/12/2025 indicated the Patient required wound care 3 times a week, and the agency would provide SN services 2 times a week for 4 weeks and then 1 time a week for 4 weeks. The POC failed to include who would provide the wound care in the absence of the SN. The POC indicated the Patient had blood sugar parameters of when to notify the physician and failed to include the frequency of the blood sugar checks. On 05/22/2025, beginning at 10:49 AM, RN 1 indicated Person 3 (nurse practitioner) provided wound care 1 time per week to the Patient in the Patient s home. The POC failed to include the services provided by Person 3. On 05/22/2025, beginning at 11:33 AM, the CM indicated the POC did not include the frequency of the blood sugar checks, who would provide the wound care in absence of the SN, and the services to be provided by Person 3. 2. A clinical record review for			

	Patient #2 evidenced a POC for the initial certification period of 05/19/2025-7/17/2025 which indicated the Patient was diabetic and indicated the parameters for when the agency was to notify the physician for high or low blood sugar. The POC failed to include the frequency of the blood sugar checks. On 05/22/2025, beginning at 11:56 AM, the CM indicated the POC did not include the frequency of the blood sugar checks. 3. A clinical record review for Patient #3 evidenced a SOC comprehensive assessment completed by RN 2 dated 03/01/2025 which indicated the Patient s weight was 146 pounds, indicated the Patient was diagnosed with failure to thrive, and the Patient had weight loss and a poor appetite. The comprehensive assessment for recertification completed by RN 2 dated 04/25/2025 indicated the Patient s weight was 138 pounds and indicated the Patient had weight loss and a poor appetite. The SN visit note dated 05/15/2025 indicated the Patient weighed			

	129 pounds. During an observation of care on 05/21/2025, at 11:25 AM, RN 2 weighed the Patient and indicated the Patient s weight was 126 pounds which was a loss of 3 pounds in 1 week. RN 2 educated the Patient on taking nutrition supplement shakes daily. RN 2 confirmed the Patient was still receiving housekeeping services paid for privately which the Patient confirmed. The POC for the initial certification period 03/01/2025-04/29/2025 and the POC for the recertification period 04/30/2025-06/28/2025 failed to evidence the SN interventions included obtaining the Patient s weight and providing education on the administration of nutrition supplement shakes. The POC failed to evidence there were any services provided by any other agency in the home. On 05/22/2025, beginning at 12:13 PM, the CM indicated the POC did not include obtaining the Patient s weight, providing education to the use of nutrition supplement shakes,			

	and the services provided by Entity 7. On 5/21/2025, at 5:41 PM, the Patient indicated they received services from Entity 7 for housekeeping and personal care services. On 5/22/2025, at 9:52 AM, Person 8 at Entity 7 indicated Entity 7 provided services to the patient for 4 hours 1 time a week to include assistance with showering, personal care, meal preparation, and light housekeeping. 4. A clinical record review for Patient #6 evidenced a POC for the initial certification period 03/31/2025-05/29/2025 which indicated the agency was to provide PT services to evaluate and treat and failed to evidence PT goals. The PT POC dated 04/02/2025 for the initial certification period 03/31/2025-04/24/2025 failed to evidence the PT goals. On 05/22/2025, at 12:22 PM, the CM indicated there were no PT goals on the POC. 5. A clinical record review for Patient #7 evidenced a POC for the initial certification period			

	03/26/2025-05/24/2025 which indicated the agency was to provide PT services to evaluate and treat and failed to evidence PT goals. The PT POC dated 03/28/2025 for the initial certification period 03/31/2025-04/24/2025 failed to evidence the PT goals. On 05/22/2025, beginning at 12:39 PM, the CM indicated the POC did not include PT goals. A revised policy, dated February 2024, titled, Care Planning Process, indicated the care planning for each patient would be individualized to include specific care or services to be provided including frequency, type, and duration. 2. A revised policy, dated February 2024, titled, Plan of Care -CMS #485 and Physician/Practitioners Orders, indicated the individualized plan of care would specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment. The policy indicated the individualized plan of care would include the following:			

	equipment required, all medications and treatments. 3. A revised policy, dated February 2024, titled, Medication Profile, indicated the admitting registered nurse [RN] would check all medications a patient was taking and document on the medication profile and would include all prescribed medications, and over the counter medications. The policy indicated the nurse would add new or changed medications to the medication profile and the medication profile would be reviewed at every home visit and updated as changes occurred. 4. A Plan of Care, for certification period, 05/09/2025 to 07/07/2025, indicated Patient #4 s diagnosis was congestive heart failure (weakness of the heart), cellulitis (inflammation of connective tissue), and type 2 diabetes mellitus (condition that affects the way the body metabolizes sugar). During a home visit observation, on 05/21/2025, beginning at 12:15 PM, Patient			

her blood sugar one time per week.

The Plan of Care failed to evidence an order for blood sugar monitoring.

During an interview, on 05/21/2025, beginning at 4:00 PM, the Administrator, Administrative Staff #1, indicated the plan of care should include interventions for blood sugar monitoring. The Administrator indicated the type 2 diabetes mellitus diagnosis should include interventions on the plan of care.

A Plan of Care, for certification period, 05/09/2025 to 07/07/2025, indicated Patient #4 s medication were atorvastatin (cholesterol medication) 20 milligrams (mg) one tablet daily, cholestyramine (cholesterol medication) 5 grams twice daily, folic acid 1 mg daily, Lasix (diuretic) 20mg one tablet daily, gabapentin (neupathic pain medication) 100 mg 2 tablets at night, hydralazine (blood pressure medication) 50 mg one tablet three times a day, leflunomide (arthritis medication) 10 mg one

	tablet daily, pantoprazole (reduces stomach acid) 50mg one tablet daily, potassium chloride 20 milliequivalents daily, prednisone 20mg (anti-inflammatory steroid medication) one tablet daily, psyllium (dietary fiber) one packet daily, accupril (blood pressure medication) 10 mg one tablet daily, and Zoloft (antidepressant medication) 50 mg one tablet daily. During an observation of a home visit, on 05/21/2025, beginning at 12:15 PM, Patient #4 indicated an entity 2, a skilled nursing facility, medication list was the correct medication list that Patient had been taking since discharge from entity 2 on 05/07/2025. An Entity 2, medication list indicated Patient s medications included but not limited to ascorbic acid (vitamin C) 250 mg one tablet daily, ergocalciferol (vitamin D) 1.25 mg one tablet weekly, Lasix 40 mg one tablet daily, gabapentin 100 mg one tablet at night, hydralazine 25mg and hydralazine 50mg to equal 75mg three times per daily, losartan (blood pressure			

	medication) 50 mg one tablet twice a daily, prednisone 20mg 3 tablets daily, Tylenol extra strength 500 mg one tablet every 6 hours as needed for pain. The Plan of Care medication list failed to include the ascorbic acid, ergocalciferol, Lasix dose of 40 mg one tablet daily, gabapentin dose of 100 mg one tablet at night, hydralazine dose of 75mg three times a daily, losartan 50 mg one tablet twice a day, prednisone dose of 20mg 3 tablets daily, and Tylenol extra strength. During a home visit observation on 05/21/2025, beginning at 12:15 PM, Patient #4 indicated he/she took Tylenol arthritis as needed, was taking prednisone 20mg 3 tablets daily, and losartan 50g one tablet twice a daily since was in entity 2. During an interview on 05/21/2025, Registered Nurse [RN] 1 indicated the plan of care medications for Lasix, hydralazine and prednisone were not as the patient was prescribed and the losartan was			

	mediation list and should have been. RN 1 indicated medications should have been reconciled at every skilled nursing visit with Patient. A Plan of Care, for certification period 05/09/2025 to 07/07/2025, indicated skilled nurse to perform wound care to arterial ulcer to top of right foot by cleaning wound with normal saline or wound wash, pat dry with gauze, apply hydrafera blue to wound bed and secure with dry dressing and the skilled nurse may teach patient/caregiver to perform wound care. The Plan of Care failed to include frequency of dressing change to right foot. During a home visit observation on 05/21/2025, beginning at 12:15 PM, Patient #4 indicated he/she changed the dressing to the right foot one time per week, the doctor changed the dressing to the right foot one time per week and the home health nurse changed the dressing to the right foot one time per week. During an interview, on 05/21/2025, beginning at 4:00 PM, the Administrator indicated			

	the wound care dressing change frequency should be included on the plan of care. 5. A Plan of Care, for certification period 03/08/2025 to 05/06/2025, for Patient #5, indicated skilled nursing to perform pressure ulcer care to left heel to include cleaning the wound with saline, apply iodosorb then alginate, and cover with adhesive foam. The Plan of Care failed to include the frequency of the dressing change. A Plan of Care, for certification period 05/07/2025 to 07/05/2025, indicated skilled nursing to perform pressure ulcer care to left outer heel to include cleaning the wound with saline, apply iodosorb then alginate, and cover with adhesive foam. The Plan of Care indicated skilled nursing would assess neurological status, instruct on disease process, medication review and management, injury prevention and provide skilled assessment. The Plan of Care failed to include the frequency of the dressing change. During an interview, on			

	05/21/2025, beginning at 4:20 PM, Registered Nurse [RN] 2 indicated the skilled nursing visits were the schedule for the dressing changes to be completed. 410 IAC 17-13-1(a)(1)(D)(ix)			
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 agency failed to ensure that services and treatments were administered only as ordered per a physician in 2 of 4 active clinical records reviewed with a patient wound (Patient #2, 5). Findings include: Based on observation, record review, and interview, the agency failed to ensure services were provided only as ordered by a physician in 1 of 1 active	G0580	1. Patient charts were audited, physicians were consulted and verbal physician orders were taken to ensure accuracy of the POC. Education was given to the clinical team as to prevent future occurrences. 2. Patient charts were reviewed to ensure all orders, including what disciplines were ordered and how frequently to be seen were followed. 3. Reviewed P&Ps relating to physician orders and ensuring that services and treatments were administered only as ordered per a physician with Clinical and QA staff. Held multiple in-services with the Clinicians and QA team regarding the need to ensure services are provided only as ordered by the physician. 4. The Clinical Supervisor and the QA team will audit all completed Plan of Cares with an audit form to ensure completeness and accuracy. 100% of new Plan of Cares will be audited for a minimum period of 90 days or until a 95% accuracy rate for comprehension and accuracy is achieved. The Clinical Supervisor and QA team will review 100% of clinician notes before approval to ensure the POC is followed precisely and all care is provided only as ordered by physician. This will continue indefinitely.	2025-06-16

clinical record reviewed with Person 5 as the physician responsible for the POC. (Patient #2)

The findings include:

A clinical record review for Patient #2 evidenced a document titled Physician Order signed by RN 1 dated 05/19/2025 which indicated the order was from the physician responsible for the plan of care. The document was not signed by the physician. The document indicated the agency was to admit the Patient to home care services and provide SN services 1 time a week for 9 weeks and PT and OT to evaluate and treat. The SOC comprehensive assessment indicated RN 1 completed a full head-to-toe assessment and completed wound care to the right foot on 05/19/2025.

PT 1 was observed providing treatment to include strengthening exercises to the lower extremities, ambulation with a walker, and transferring assistance at the Patient s home on 05/20/2025 beginning at 2:02 PM.

On 05/22/2025, at 10:49 AM,

RN 1 indicated Person 5, the physician responsible for the POC, was on vacation, and she had not had any communication with Person 5. RN 1 indicated the SOC order was written as a standard order that gets sent to the physician at SOC.

On 05/22/2025, at 12:03 PM, the CM indicated Person 5 was on vacation and on 05/21/2025 she spoke to the physician on-call but not before the SOC assessment and wound care on 05/19/2025 and the PT evaluation and treatment on 05/20/2025, and the CM indicated the communication with the on-call physician was for the notification of the drug interactions and not the SOC orders.

A revised policy, dated February 2024, titled, Plan of Care CMS #485 and Physician/Practitioners Orders, indicated care and services provided would be provided according to physician orders.

A Plan of Care, for certification period 03/08/2025 to 05/06/2025, indicated skilled

sing visits 1 time a week for 1 ek, then 2 times per week for 4 eks and then 1 time a week for 4 eks. The Plan of Care indicated led nursing was to perform ssure ulcer care to the left outer el.

A Plan of Care, for certification period 05/07/2025 to 07/05/2025, indicated skilled nursing visits 1 time a week for 9 weeks. The Plan of Care indicated skilled nursing was to perform pressure ulcer care to the left outer heel.

The Plans of Care failed to evidence frequency of left heel dressing changes.

A clinical record review, on 05/21/2025, failed to evidence the plan of care physician was notified of the wound care frequency change.

During an interview, on 05/21/2025, beginning at 4:20 PM, Registered Nurse [RN] 2 indicated she made the decision to decrease dressing change frequency to one time per week because the wound was no longer draining and the doctor would be notified by the plan of care. RN 2 indicated she did not need an order to change

	the frequency in wound care. 410 IAC 17-13-1(a)			
G0584	Verbal orders 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. Based on record review, and interview, the agency failed to ensure physician or practitioner s verbal orders were documented in the patient s clinical record and the orders were signed and dated in 1 of 1 active clinical records reviewed for a patient residing in	G0584	1. Patient charts were audited to ensure that verbal orders were accurate and compliant with agency policy and regulations. Education was given to the clinical team as to prevent future occurrences. 2. Patient charts were reviewed to ensure all verbal orders are documented appropriately. 3. Reviewed P&Ps relating to physician verbal orders and ensuring that verbal orders taken by appropriate clinicians and are are documented in the patient's clinical record, signed, dated and timed. Held multiple in-services with the Clinicians and QA team regarding the need to ensure order accuracy and completeness. 4. The Clinical Supervisor and the QA team will audit 100% of all verbal orders taken to ensure regulatory compliance. This will continue indefinitely.	2025-06-16

	(Patient #1). Findings include: A revised policy, dated February 2024, titled, Physician/Practitioner Orders Verbal Orders, indicated when a verbal order was received, the order would be written down, ready back to verify the order and the orders would include the patient s name, physician/practitioner s name/ date and time the order was taken, the signature of the person taking the order and the specific order. The policy indicated the original order was mailed or taken for signature.			

Plans of Care, for certification period 03/08/2025 to 05/06/2025 and 05/07/2025 to 07/05/2025, for Patient #5 indicated skilled nursing was to perform pressure ulcer care to left heel by cleaning the wound with saline, applying iodosorb then alginate, cover with adhesive form dressing.

An order, dated 01/30/2025, from physician 4 indicated left heel clean with normal saline/wound cleaner, pat dry, paint with betadine and leave open to air.

An order, dated 03/07/2025, from physician 4 indicated discharge patient to entity, 1, a nursing facility with home health services.

A start of care comprehensive assessment, dated 03/08/2025, indicated the left heel was cleaned with saline, iodosorb was applied then alginate dressing and covered with an adhesive foam dressing.

A Physician order, dated 03/08/2025, indicated start of care orders and care coordination was with the plan of care physician was

	personnel on 03/10/2025 regarding initial/assessment/admission and start of care and the home health plan of care was to follow. The physician order failed to evidence wound care orders. During an interview, on 05/21/2025, beginning at 4:20 PM, RN 2 indicated nurse practitioner 3 of a wound care medical group provided wound care orders for Patient. RN 2 indicated she called to the doctor to tell the doctor about the wound. During an interview, on 05/22/2025, beginning at 9:30 AM, the Administrator, administrative staff 1, indicated Patient #5 wound care was provided by nurse practitioner 3 and would need to call nurse practitioner 3 to obtain documentation of care provided for Patient #5. The Administrator indicated when nurse practitioner 3 gave wound care orders the order would need to be written and included in documentation in the electronic medical record. A clinical record review on			

	05/22/2025, failed to evidence orders from nurse practitioner 3. During a follow up interview, on 05/22/2025, beginning at 4:00 PM, the Administrator indicated nurse practitioner 3 needed to complete the notes prior to sending them to the agency. Upon exit, on 05/22/2025 at 5:00 PM no notes from nurse practitioner 3 had not been received. 410 IAC 17-14-1(a)(H)			
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 observation, record review, and interview, the agency failed to ensure the physician was notified of changes in the patient's condition that suggest the POC may need to be changed in 3 of 5 active clinical records reviewed. (Patient #1, 2, 3).	G0590	1. Patient charts were audited to identify if the physician needed to be alerted of any significant changes to patient condition or needs not being met and addendum orders were completed as needed. If it was identified that we were struggling to meet a patient's needs the doctor was consulted and a plan was put into place to address the issue up to and including transferring the patient to another agency that can better meet the patients needs. Education was given to the clinical team as to prevent future occurrences. 2. Patient charts were audited to check for any declines or additional patient needs not being met.	2025-06-16

	Findings include: 1. A clinical record review for Patient #1 evidenced a SOC comprehensive assessment dated 04/14/2025 which indicated the Patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) Stage III (an open pressure ulcer with full thickness loss of skin) to the sacrum (lower back). SN visit notes completed by LPN 1 indicated the wound measured 1.5 centimeters (cm) in length, 2.0 cm in width, and 1.5 cm in depth on 04/18/2025; 1.7 cm in length, 2.0 cm in width, and 1.5 cm in depth on 04/21/2025; 2.0 cm in length, 2.0 cm in width, and 1.5 cm in depth on 04/25/2025; and 4.0 cm in length, 4.5 cm in width, and 1.5 cm in depth on 05/02/2025. The record failed to evidence the agency notified the physician of the increase in wound size as noted on 05/02/2025. On 05/22/2025, beginning at 10:49 AM, RN 1 indicated she only communicated to Person 3 (nurse practitioner) in regard to the wound since Person 3 was		3. Reviewed P&Ps relating to promptly alerting the physician of changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or the plan of care should be altered with Clinical and QA staff. Held multiple in-services with the Clinicians and QA team regarding the need to ensure the physician is promptly alerted to any changes in patient's condition. 4. The Clinical Supervisor and the QA team will audit 100% of patient POCs and clinical visit notes to ensure adherence to policy and physician notification to any significant changes in the patients condition. 100% of new Plan of Cares will be audited with the POC audit tool for a minimum period of 90 days or until a 95% accuracy rate for comprehension and accuracy is achieved. 100% of Clinical visits will be audited indefinitely by the Clinical Supervisor and QA team.	

	the practitioner managing the wound. On 05/22/2025, at 11:42 AM, the CM indicated there was no documentation the agency notified the physician responsible for the POC of the increase in wound size. 2. 1. A clinical record review for Patient #2 evidenced a SOC comprehensive assessment dated 05/19/2025 which indicated the Patient required assistance with personal care, activities of daily living (ADLs), and feeding and lived at home with a caregiver. The record failed to identify if the caregiver was willing and able to provide the required care and failed to evidence the agency inquired if the Patient would be interested in HHA services to assist with care. On 05/20/2025, at 2:28 PM, the Patient s caregiver indicated they were 71 years old, had open heart surgery, and indicated it was physically taxing to provide personal care and assist with ADLs. The Patient s caregiver indicated the CM informed the Patient the			

HHA to assist in a week or so.

At the entrance conference on 05/19/2025, beginning at 3:20 PM, the CM indicated the agency provided HHA services but currently had no HHA and did not have a contract with another agency to provide HHA services. The CM indicated the agency was trying to hire HHAs to provide HHA services.

On 05/20/2025, at 3:30 PM, the CM indicated she did inform the Patient s caregiver the agency would be able to provide a HHA soon and indicated she thought the agency would have a HHA hired and ready to staff the Patient in a couple of weeks.

On 05/22/2025, at 11:56 AM, the CM indicated the agency did not inform the physician of the inability to provide HHA services as needed.

3. A clinical record review for Patient #3 evidenced a SOC comprehensive assessment dated 03/01/2025 which indicated the Patient s weight was 146 pounds, and the comprehensive assessment for recertification dated 04/25/2025 indicated the Patient s weight

	weight loss of 8 pounds. SN visit note dated 05/15/2025 indicated the Patient weighed 129 pounds. During an observation of care on 05/21/2025, at 11:25 AM, RN 2 weighed the Patient and indicated the Patient s weight was 126 pounds which was a loss of 3 pounds in 1 week. RN 2 indicated one of the reasons for SN services was for the Patient s diagnosis of failure to thrive and to monitor the Patient s weight. The record failed evidence the agency notified the physician of the continued weight loss of 20 pounds since the admission on 03/01/2025. On 05/21/2025, at 4:24 PM, RN 2 indicated she was unsure if she had notified the physician of the Patient s weight loss. On 05/22/2025, at 12:13 PM, the CM indicated she did see any documentation the physician was notified of the weight loss.			

410 IAC 17-13-1(a)(2)

A revised policy, dated February 2024, titled, Medication Profile, indicated the comprehensive assessment performed at the time of admission would include a review of all medications that the patient was taking in order to identify potential adverse effects and drug reactions including significant side effects, significant drug interactions and duplicate drug therapy. The policy indicated the admitting registered nurse [RN] would check all medications a patient was taking and document on the medication profile and all prescribed medication and over the counter medications would be documented.

Medication Profiles, for Patient #4, dated 05/09/2025 and 05/13/2025, indicated

	ient was taking accupril (blood ssure medication) 10 milligrams g) one tablet every day, rvastatin (cholesterol lowering dication) 20 mg one tablet daily, lestyramine (4 grams (gm) ce daily, folic acid 1 mg one let daily, to gabapentin upathic pain medication) 100 s 2 tablets every night, lralazine (blood pressure dication), 50mg one tablet 3 es per day, Lasix (diuretic) 20 one tablet daily, leflunomide hritis medication) 10 mg one let daily, pantoprazole (acid ucing medication) 40 mg one let daily, potassium chloride 20 liequivalents one tablet daily, dnisone (anti-inflammatory roid) 20 mg one tablet daily, llium (dietary fiber) one packet ly, and zoloft (antidepressant) 50 one tablet daily. The dication Profiles were signed by 1 on 05/09/2025 and 13/2025 and indicated the dications were reviewed for ential adverse effects, drug ctions including significant side ects, and significant drug eractions. During an observation of a home visit on 05/21/2025, beginning at 12:15 PM, Patient			

	from entity 2, a skilled nursing facility was her/his medication list and indicated Patient was taking ascorbic acid (vitamin C) 250 mg one tablet daily, cholestyramine (cholesterol medication) 4 gm one packet twice daily, ergocalciferol 1.25 mg one capsule weekly, folic acid 1 mg one tablet daily, Lasix 40 mg one tablet daily, gabapentin 100 mg one tablet in the evening, hydralazine 25 mg and 50 mg to equal 75mg three times a day, leflunomide 10 mg one tablet daily, atorvastatin 20 mg daily, losartan (blood pressure medication) 50 mg one tablet twice daily, polysaccharide iron 150m mg one capsule twice a day, potassium chloride 10 milliequivalents 2 tablets every day, prednisone 20 mg three tables daily, protonix 40 mg one tablet daily, sertraline 50 mg one tablet daily and Tylenol extra strength 500 mg one tablet every 6 hours as needed. Patient indicated he/she used Tylenol Arthritis as needed. The agency s medication profiles failed to evidence the losartan, and Tylenol. A drugs.com interaction check			

indicated major drug interactions between losartan and potassium that could elevate potassium levels in the body, and major drug interactions between Tylenol and leflunomide that could cause liver problems.

A Comprehensive Assessment, dated 05/09/2025, indicated medications were reconciled and no issues found during review.

An agency s Drug-Drug Interactions dated 05/21/2025 indicated moderate reactions between accupril and potassium chloride, Lasix and cholestyramine, cholestyramine and leflunomide, prednisone and leflunomide, atorvastatin and leflunomide, and Lasix and leflunomide.

A clinical record review failed to include documentation the physician was notified of the drug to drug interactions.

During an interview on 05/21/2025, beginning at 1:00 PM, RN 1 indicated the physician would be notified of the drug to drug interactions noted, and she would call the physician with the interactions

	and would document when the physician was notified. 410 IAC 17-13-1(a)(2)			
G0602	Communication with all physicians 484.60(d)(1) Standard: Coordination of Care. The HHA must: (1) Assure communication with all physicians or allowed practitioners involved in the plan of care. Based on record review and interview, the agency failed to ensure communication with all practitioners providing care to the patient in 2 of 3 active clinical records reviewed with wounds receiving care from Person 3. (Patient #1, 5) The findings include: 1. A clinical record review for Patient #1 evidenced a SOC comprehensive assessment dated 04/14/2025 which indicated the Patient had a pressure ulcer (wounds to the	G0602	1. Patient charts were audited to check for communication with all physicians. If multiple physicians were involved in a patient's care they were added to the medical chart to ensure the team knew of and was able to communicate with all physicians or allowed practitioners. Patient visit notes will be added to the patient charts when received from allowed practitioners. Education was given to the clinical team as to prevent future occurrences. 2. Patient charts were audited to check for accuracy of care team members and communication with all physicians. 3. Reviewed P&Ps relating to ensuring communication with all physicians or allowed practitioners of a patients care team. Held multiple in-services with the Clinicians and QA team regarding the need to ensure good communication and coordination of care. 4. The Clinical Supervisor and the QA team will audit 100% of patient POCs and clinical visit notes to ensure adherence to policy with physician notification of any significant changes in the patients condition. 100% of new Plan of Cares will be audited with the POC audit tool for a minimum period of 90 days or until a 95% accuracy rate for comprehension and accuracy is achieved. 100% of Clinical visits will be audited indefinitely by the Clinical Supervisor and QA team.	2025-06-16

resulting from prolonged pressure to the skin) Stage III (an open pressure ulcer with full thickness loss of skin) to the sacrum (lower back).

On 05/22/2025, beginning at 10:49 AM, RN 1 indicated Person 3 (nurse practitioner) provided wound care 1 time per week in the Patient s home. The clinical record failed to evidence any care coordination with Person 3.

On 05/22/2025, at 11:42 AM, the CM indicated there was not yet any documentation of care coordination with Person 3 regarding the wound care.

#. Plans of Care, for certification periods 03/08/2025 to 05/06/2025 and 05/07/2025 to 07/05/2025 indicated Patient #5 required skilled nursing for wound care to left heel. The Plans of Care failed to evidence documentation of nurse practitioner 3, a wound care medical group provided wound care orders for Patient.

During an interview, on 05/21/2025, beginning at 4:20 PM, RN 2 indicated nurse practitioner 3 of a wound care

	care orders for Patient. During an interview, on 05/22/2025, beginning at 9:30 AM, the Administrator, administrative staff 1, indicated Patient #5 wound care was provided by nurse practitioner 3 and she would need to call nurse practitioner 3 to obtain documentation of care provided for Patient #5. The Administrator indicated when nurse practitioner 3 gave wound care orders the order would need to be written and included in documentation in the electronic medical record. A review of the clinical record, on 05/22/2025, failed to include documentation of communication with nurse practitioner 3. 410 IAC 17-14-1(a)(1)(G)			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and	G0606	1. Patient charts were audited to check for documented integration of services and coordination with all disciplines and other agencies providing care in the home. Patient communication or visit notes will be added to the patient's chart when received from involved practitioners. Clinicians will coordinate and integrate services when another entity is involved in the patient's care and document this communication in their clinical notes. Education was given to the	2025-06-16

	treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the agency failed to coordinate care with all disciplines and other agencies providing care in the home in 2 of 5 active clinical records reviewed. (Patient #1, 2) The findings include: 1. A clinical record review for Patient #1 evidenced a SOC comprehensive assessment dated 04/14/2025 which indicated the Patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) Stage III (an open pressure ulcer with full thickness loss of skin) to the sacrum (lower back). SN visit notes completed by LPN 1 indicated the wound measured 1.5 centimeters (cm) in length, 2.0 cm in width, and 1.5 cm in depth on 04/18/2025; 1.7 cm in length, 2.0 cm in width, and 1.5 cm in depth on 04/21/2025; 2.0 cm in length, 2.0 cm in width, and 1.5 cm in depth on 04/25/2025; and 4.0 cm in length, 4.5 cm in width, and 1.5 cm in depth on 05/02/2025. The record failed to evidence LPN 1 notified the RN case manager of the increase in wound size as		clinical team as to prevent future occurrences. 2. Patient charts were audited to check for the integration of services and coordination between care team members. 3. Reviewed P&Ps relating to ensuring communication with all physicians or allowed practitioners of a patients care team. Held multiple in-services with the Clinicians and QA team regarding the need to ensure good communication and coordination of care. A weekly care coordination takes place with the clinical staff and the members of the QA team. 4. The Clinical Supervisor and the QA team will audit 100% of patient POCs and clinical visit notes to ensure adherence to policy of integration of all services and care coordination between care team members. 100% of new Plan of Cares will be audited with the POC audit tool for a minimum period of 90 days or until a 95% accuracy rate for comprehension and accuracy is achieved. 100% of Clinical visits will be audited indefinitely by the Clinical Supervisor and QA team.	

	noted on 05/02/2025. On 05/22/2025, at 11:42 AM, the CM indicated there was no documentation the LPN notified the RN case manager of the size increase. 2. On 05/21/2025, at 11:25 AM, RN 2 indicated Patient #2 was receiving housekeeping services paid for privately by the Patient. On 5/21/2025, at 5:41 PM, Patient #2 indicated they received services from Entity 7 for housekeeping and personal care services. On 5/22/2025, at 9:52 AM, Person 8 at Entity 7 indicated Entity 7 provided services to the patient for 4 hours 1 time a week to include assistance with showering, personal care, meal preparation, and light housekeeping. The clinical record failed to evidence care coordination by the agency with Entity 7. On 05/22/2025, at 12:18 PM, the CM indicated there was no care coordination with Entity 7. 410 IAC 17-12-2(g)			

	410 IAC 17-12-2(h)			
G0642	Program scope 484.65(a)(1),(2) Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. Based on record review, and interview, the agency s Quality Assessment and Performance Improvement [QAPI] program failed to analyze patients falls adverse events and implement preventive actions for 5% of unduplicated 12 month census with patients falls from 04/01/2024 to 05/22/2025 (Patient #8, Patient #9, Patient #10, Patient #11, Patient #12, Patient #13, Patient #14, Patient #15). Findings include: A revised policy, dated	G0642	1. QAPI program was analyzed and the program scope was enhanced to understand, measure and track quality indicators of recent falls. Educational deficits were identified as being an issue and patient education was found and implemented to be given out to all patients at SOC. Current patients will be given the material by their case manager. 2. Reviewed data from last 12 months of falls, reviewed fall reports and completed a root cause analysis of problem. 3. Reviewed patient education given at SOC and patient education needed on a continuous basis to ensure safety. The specifics of a home safety check and the educational resources in the SOC book were reviewed. Newly implemented fall prevention 4. Fall prevention will continue to be a focus of our Quality Assessment and Performance Improvement program. 100% of falls will be reviewed by the Clinical Manager to understand the circumstances and how the fall might have been prevented. This will continue indefinitely. QAPI analysis is done on an ongoing basis and reviewed with the team quarterly. Patient data on falls will be analyzed and reviewed at our next QAPI meeting and the findings will be reported to the board.	2025-06-16

	ıruary 2024, titled, Quality urance and Performance ɔrovement [QAPI] Plan and gram, indicated the agency uld be capable of showing asurable improvement in icators for which improvement hose indicators would improve ılth outcomes, patient safety and ılity of care. A revised policy, dated February 2024, titled, Variance/Incident Reporting, indicated Variance/Incident Reports would be forwarded to the QAPI committee for the purpose of reviewing, analyzing, aggregating, trending and making performance improvement recommendations. An Incident Surveillance Report, for 04/01/2024 to 06/20/2025, indicated Patient #10, Patient #11, Patient #13, Patient #14, and Patient #16 had documented falls with injury; and Patient #12, and Patient #15 had falls without injury. A Hospitalization Log indicated Patient #9 was admitted 04/20/2025 for a fall, and			

	an unknown admission date for a fall. A QAPI Plan Q4 2024 failed to evidence patients falls were identified to analyze to implement preventive actions. QAPI Meeting Minutes for 01/08/2025, and 04/02/2025, failed to evidence patients falls were analyzed to implement preventive actions. During an interview on 05/22/2025, beginning at 3:10 PM, the Administrator indicated patients falls were not part of the agency s performance improvement program. 410 IAC 17-12-2(a)			
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure the clinical record was	G1024	1. Patient charts were audited and notes with duplicated entries or narratives were returned to the clinicians for correction. Education was given to the clinical team as to prevent future occurrences. 2. Patient charts that were identified as containing narrative duplication were returned to the clinicians for correction.	2025-06-16

	accurate in 1 of 2 clinical records reviewed with services provided by a LPN. (Patient #1) The findings include: A clinical record review for Patient #1 evidenced SN visit notes completed by LPN 1 and dated 04/18/2025, 04/21/2024, 04/25/2025, 05/02/2025, 05/09/2025, and 05/11/2025 which indicated the LPN documented the visit narrative the same for all visits. On 05/22/2025, at 11:41 AM, the CM indicated the LPN was on vacation and not available for interview and indicated the LPN must have carried over the narrative from one visit to the next. 410 IAC 17-15-1(b)		3. Reviewed P&Ps relating to the comprehensive assessment and documentation standards with Clinical and QA staff. Held multiple in-services with the Clinicians and QA team regarding the need to ensure the comprehensive assessment includes the current health and functional status of the patient specifically addressing any patient specific issues. Copy and pasted narratives are unacceptable and the clinicians need to be aware of this occurring. 4. The Clinical Supervisor and the QA team will audit all completed Plan of Cares and visit notes to ensure completeness and accuracy. Specific attention will be paid to ensure documentation of visit specificity and no duplication of narratives. 100% of all clinical documentation will be reviewed by Clinical Supervisor and QA team until further notice.	
N0000	Initial Comments This visit was for a State Re-Licensure survey of a home health provider. Survey Dates:	N0000	Initial Comments	

	05/19/2025-05/22/2025 Unduplicated 12 month skilled admissions: 190			

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
Christie Castor	Administrator	6/17/2025 4:56:04 PM