STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157578	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMEDISYS HOME HEALTH	1332 W ARCH HAVEN AVE STE E, BLOOMINGTON, IN, 47403

(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
N0000	Initial Comments This visit was for a State Re-Licensure survey of a deemed Home Health Provider. Survey Dates: 05/19/2025-05/22/2025 12-Month Unduplicated Skilled Admissions: 4511 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Abbreviations: OT-Occupational Therapist COTA-Certified Occupational Therapist PTA- Physical Therapy Assistant	N0000	Alleged deficiencies to be corrected by 6.21.25	

	SN-Skilled Nurse RN-Registered Nurse LPN- Licensed Practical Nurse POC-Plan of Care SOC-Start of Care			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health 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.	N0458	**N0458 Home health agency administration/management** The administrator/Director of Operations will be responsible for correctingthis deficiency. All active and current agency and contract staff will receive training onthe following policies/procedures and will be documented as evidenced bysign-in sheet by 6.21.25: Policy HR-001(a) Personnel File Requirements for Agency Staff All active and current agency staff employee files for provider will beaudited for required documentation including evidence of job orientation andannual performance evaluations as applicable for 100% compliance according toAmedisys Policy HR-001(a) by 6.21.25	2025-06-21

	Based on record review and interview, the agency failed to ensure orientation documentation and annual performance evaluations were conducted and maintained in the personnel record for 2 of 3 LPN record reviews and 1 of 2 RN record reviews. (LPN 1, LPN 3, RN 2) Findings include: 1. A 07/01/2024 policy titled "Personnel File Requirements" indicated that the agency must maintain up-to-date information regarding employee qualifications, orientation, and job evaluations. The policy states that the agency must comply with state-specific requirements, as outlined in Indiana 410 IAC 17-12-1. 2. The personnel record review of LPN 1, with a hire date of 03/11/2024, failed to provide evidence of job orientation. 3. The personnel record review of RN 2, with a hire date of		New job orientation, competencies, on-site visits, and performanceevaluations will take place by provider clinician managers or pod peer mentorto correct any deficiencies identified in audit and as alleged in the statementof deficiencies as applicable for LPN1, LPN 3 and RN2. These will be completed by 6.21.25 Monitoring process: Administrator/Director of Operations, Alternate Administrator, OfficeManager, or Area Vice President of Clinical or Operations of the agency willperform 15 employee file audits quarterly for compliance with Policy HR-001(a).5 files each will be audited from parent and branches and as part of regularQAPI process. All education will be completed with active and current agency by 6.21.25	

	01/23/2023, failed to provide evidence of job orientation. 4. The personnel record review of LPN 3, with a hire date of 11/02/2020, failed to provide evidence of an annual performance evaluation for 2024. 5. During an interview on 05/22/2025, at 9:55 AM, the Office Manager was unable to locate the requested information for LPN 1, LPN 2, and RN 2. She was unsure why the items were missing.			
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. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be	N0464	**N0464 Home Health Administration/ Management** The administrator/Director of Operations will be responsible for correctingthis deficiency. All active and current agency staff and contract employee files for providerwill be audited by 6.21.25 for required tuberculosis screening and requireddocumentation for 100% compliance according to Amedisys Policy TBP-003 Tuberculosis Screening and Testing	2025-06-21

	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 agency failed to ensure compliance with the		Any active and current agency or contracted staff noted to be out ofcompliance with Policy TBP-003 will refrain from direct patient care untilrequirements are satisfied. Provider will create and maintain in-house contracted employee personnelfiles by 6.21.25 to ensure compliance with Amedisys Policy LD-009 ContractedPatient Services and TBP-003 Tuberculosis Screening and Testing to ensureongoing monitoring of required tuberculosis screening and required documentation. LPN 2, OT 2, and PTA 2, as well as contracted employees identified will haveproduced required documentation or restarted required tuberculosis screeningprocess by 6.5.25 All active and current agency and contract staff will receive training onthe following policies/procedures and will be documented as evidenced bysign-in sheet by 6.21.25: Policy TBP-003 Tuberculosis Screening and Testing	

	state statute, which requires a two-step tuberculosis (TB) (contagious disease) skin test upon hire and annual symptom screening for employees for 2 of 2 contracted employees and for 1 of 3 LPN records reviewed. (LPN 2, OT 2, PTA 2) Findings include: 1. A 07/01/2024 policy titled Personnel File Requirements indicated the agency must maintain up-to-date information regarding employees' TB screening questionnaires and TB test upon hire. The policy includes that the agency must comply with state-specific requirements as outlined in Indiana 410 IAC 17-12-1. 2. The personnel record review of LPN 2, hire date 01/23/2023, failed to evidence a first and second-step TB Skin Test upon hire. During an interview on 05/22/2025 at 9:25 AM, LPN 2 stated that the Bedford Health Department performed her TB test. She stated she had told the Health Department to send the results to the agency, but never		Policy LD-009 Contracted Patient Services Monitoring process: Administrator/Director of Operations, Alternate Administrator, OfficeManager, or Area Vice President of Operations/Clinical of the agency willperform a combination of 5 employee file and contracted personnel file auditsquarterly for compliance with Policy TBP-003 from parent and branches and aspart of regular QAPI process x 2 quarters. All education will be completed with active and current staff and contractemployees by 6.21.25	

	Resource Personnel stated there was no follow-up to ensure the agency received the results. 3. The personnel record review of OT 2, with a hire date of 05/23/2022, failed to evidence a second-step TB skin test upon hire. 4. The personnel record review of PTA 2, with a hire date of 04/17/2023, failed to evidence a second-step TB skin test upon hire. During an interview on 05/22/2025 at 9:55 AM, the Alternate Administrator stated she could not find the second-step TB results for OT 2 and PTA 2. She was unsure why the agency did not complete the test.			
N0470	Home health agency administration/management 410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record	N0470	**N0470 Home Health agency administration/management** The administrator/Director of Operations will be responsible for correctingthis deficiency. All active agency clinical staff, contracted employees, andmanagement staff will receive training on the following policies/procedures andwill be documented and evidenced by	2025-06-21

	review, and interview, the agency staff failed to remove gloves and perform hand hygiene after catheter insertion for 1 of 1 skilled nursing observations performing catheter insertion. (RN 2), and after removing and re-applying gloves for 6 of 7 home visit observations. (COTA, OT, RN 2, RN 4, LPN 1, LPN 2)) Findings include: 5. During an observation on 05/20/2025 at 1:05 PM, COTA 1 documented on the electronic device and then laid the device on the back of Patient #11's recliner. COTA reviewed medication with Patient #11 and then returned to the table to clean barrier. COTA 1 failed to place a barrier on the recliner before placing the dirty device on the surface. He also failed to clean the device before placing it on the clean barrier. 6. During an observation on 05/20/2025 at 11:35 AM, LPN 2 placed the nursing bag on a clean drape, allowing the shoulder strap to lay on Patient #13's bed with no barrier. LPN 2 placed clean wound care		sign-in sheet/ attendance list by 6.21.25. Policy PCP-001: Hand Hygiene Policy PCP-002: Bag Technique Policy WC-001: The Provision of Wound and Skin Care Policy UR-001 Urinary Catheter Insertion-Straight, Indwelling or SuprapubicCatheter Corrective Action: All active clinical staff received education regarding the above policiesand procedures. All active clinical staff received visual demonstration andskills competency on proper bag technique and hand hygiene with repeatclinician demonstration as evidenced by signed statement of receipt by 6.12.25 For patient #12, RN2 will receive 1:1 education and individual skillscompetency regarding Policy UR-001: Urinary Catheter Insertion-Straight,Indwelling or Suprapubic Catheter and Policy PCP-001 Hand Hygiene as evidencedby signed statement of receipt by 6.12.25 For patient #11, COTA 1 will	

	supplies and clean gloves on top of Patient #13's items on the chair side table without using a barrier. LPN 2 applied gloves from the chair side table and then provided wound care; LPN failed to perform Hand Hygiene before applying gloves. During an interview on 05/20/2025 at 11:35 AM, LPN 2 indicated the shoulder strap should not have touched Patient #13's bed, and staff should hand hygiene before and after gloving. She indicated she could place the wound care supplies on top of the Patient's items on the chair side table without a barrier because wound care supplies are still in the package. During an interview on 05/21/2025 at 12:15 PM, the Administrator indicated staff should place a barrier between the shoulder strap and bed and between wound care supplies and chair side table. 7. During an observation on 05/21/2025 at 10:50 AM, LPN 1 disinfected the thermometer, oximeter, and blood pressure cuff and laid the clean equipment on the dirty barrier		receive 1:1 education and individual skillscompetency regarding Policy PCP-002: BagTechnique as evidenced by signed statement of receipt by 6.12.25 For patient #13, LPN 2 will receive 1:1 education and individual skillscompetency regarding Policy PCP-001: Hand Hygiene and Policy PCP-002: Bag Technique as evidenced by signed statement of receipt by 6.12.25 For patient #17, RN 4 will receive 1:1 education and individual skillscompetency regarding Policy PCP-001: Hand Hygiene as evidenced by signed statement of receipt by 6.12.25 For patient #14, LPN 1 will receive 1:1 education and individual skillscompetency regarding Policy PCP-001: Hand Hygiene and Policy PCP-002: Bag Technique as evidenced by signed statement of receipt by 6.12.25 For patient #15, OT 1 will receive 1:1 education and individual skillscompetency regarding Policy PCP-001: Hand Hygiene and Policy PCP-002:	

	with dirty supplies (cooler). LPN 1 allowed the equipment to dry and placed it in a nursing bag without recleaning. LPN 1 failed to follow infection control procedures. LPN 1 donned gloves, removed Vitamin D from the medication planner and removed gloves. LPN failed to perform hand hygiene before or after gloving. LPN 1 documented it on an electronic tablet and then provided it to Patient #14's caregiver, who signed and returned it to LPN 1. LPN 1 failed to disinfect the electronic tablet before or after the caregiver touched it. During an interview on 05/21/2025 at 12:10 PM, LPN 1 indicated staff should hand hygiene before and after gloving; she should have cleaned the electronic tablet before giving it to the caregiver to sign, and there should be a clean barrier to lay equipment to dry on after being disinfected. 8. During an observation on 05/21/2025 at 3:35 PM, OT 1 donned gloves, placed a stethoscope around his neck, secured a blood pressure cuff to Patient # 15's arm, removed the		signed statement of receipt by 6.12.25 Monitoring Process: Administrator/Director of Operations, Alternate Administrator, ClinicalManager, or Pod Peer Mentor of the agency will perform 15 total on-site in-homevisits quarterly to be comprised of 5 visits each for Parent and each Branch toassess compliance with Amedisys Policies PCP-001, PCP-002, W-001, and UR-001respectively until 100% compliance with visits has been met x 2 quarters with arecord kept of findings. This will continue to be monitored as part ofagency QAPI program review. All education to be completed by 6.21.25	

	stethoscope from around his neck, and used it to take blood pressure. OT 1 failed to perform hand hygiene before gloving, and he failed to clean the stethoscope after removing it from the neck and before using it on Patient #15. OT 1 documented on electronic devices and then handed it to Patient #15 to sign; Patient #15 returned the devices to OT 1. OT 1 failed to clean devices before or after Patient #15 signed the device. During an interview on 05/21/2025 at 12:15 PM, the Administrator indicated staff should clean the stethoscope after removing it from the neck and before using it on the patient. 1. A 05/07/2025 policy titled "Standard Precautions" indicates staff should disinfect patient care equipment after use. 2. A 06/26/2024 policy titled "Hand Hygiene" indicated that staff should perform hand hygiene before direct patient contact, applying gloves, and removing gloves. 3. A 05/12/2025 policy titled			

	"Urinary Catheter Insertion, Straight, Indwelling or Suprapubic Catheter" indicated staff should remove gloves and perform hand hygiene once the suprapubic catheter is in place and secured. 4. A 06/26/2024 policy titled Bag Technique indicated that staff should place bags on a barrier in the patient's home. The staff should not place bags on padded furniture, such as sofas or beds, without a barrier. The staff should not place the bag on the patient's floor in the home. The staff are to hang on a doorknob or the back of a heavy chair. The staff should clean their hands before accessing materials from the supplies in the bag. 5. During an observation on 05/20/2025 at 9:00 AM, RN 2 performed a suprapubic insertion for Patient #12 with gloved hands. Once inserted, RN 2 threaded the collection bag through the Patient's pants while still gloved. RN 2 failed to remove gloves and perform hand hygiene after inserting the catheter. During an interview on			

	05/20/2025 at 10:00 AM, RN 2 stated she should perform hand hygiene before and after patient care and between glove changes. 6. During an observation on 05/21/2025 at 9:00 AM, RN 4 provided wound care to Patient #17's left leg. RN 4 cleaned four open areas using a gauze dressing while wearing gloves. RN 4 removed her gloves and re-applied clean gloves. RN 4 failed to perform hand hygiene between glove changes. During an interview on 05/21/2025 at 9:40 AM, RN 4 stated she was to perform hand hygiene between changing gloves.			
N0514	Patient Rights 410 IAC 17-12-3(c) Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on	N0514	**N0514Patient Rights** The Administrator/Director of Operations will be responsible for correctingthis deficiency. All active clinical staff and management staff will receive training on thefollowing policies/procedures and will be documented as evidenced by sign-insheet:	2025-06-21

	behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. Based on record review and interview, the agency staff failed to provide patients with accurate medication records in their homes as per their agency policy for 4 of 7 record reviews with home visits. (Patients #12, #13, #14 #16) Findings include: 3. During an observation on 05/20/2025 at 11:35 AM, there was no evidence of a current medication list in Patient #13's home. LPN 2 failed to collect a current medication list from Entity 2 and reconcile medication during Patient #13's visit. During an interview on 05/20/2025 at 11:35 AM, LPN 2 indicated the agency requires a weekly medication reconciliation. 4. During an observation on 05/21/2025 at 10:50 AM, LPN 1 delivered a current medication list to Patient # 14 dated 05/19/2025. There was no prior medication list in the home.		Policy CR-MA-002 Drug Regimen Review PolicyTX-001 Physician Orders and Medical Supervision of the Plan of Care PolicyAA-014 Plan of Care (POC)/Care Planning Process Educationprovided on 6.3.25 and 6.4.25 to parent and branch clinical staff regardingmedication reconciliation. Allclinical staff will receive new hire/annual competency and skills checklistsand annual on-site evaluation visits with medication reconciliation specificeducation by 6.21.25 as evidenced in employee files and sign-in sheet. For Patient #12, complete and successful medication reconciliation will becompleted by 6.12.25. RN2 will receiveadditional 1:1 education regarding medication reconciliation in accordance withPolicies CR-MA-002 Drug Regimen Review, TX-001 Physician Orders and MedicalSupervision of the Plan	

	LPN 1 reviewed the 05/19/2025 medication list with Patient #14's caregiver and found that the Patient has been taking Hydrochlorothiazide (water pill) since 05/06/2025 (date on prescription). A record review of Patient #14 indicated that the Patient had a POC with a certification date of 04/07/2025 to 06/05/2025, which failed to evidence hydrochlorothiazide on Patient #14's medication list. During an interview on 05/21/2025 at 12:10 PM, LPN 1 indicated the staff should reconcile medication at every visit. 7. During an interview on 05/21/2025 at 12:15 PM, the Administrator indicated she is aware the agency has an issue with the medication reconciliation not being completed and the home medication not being accurate with the agency's medication list. She indicated that the staff should complete a medication reconciliation every visit. 8. During an interview on 05/21/2025 at 12:15 PM, the Area Care Manager indicated		of Care and Policy AA-014 Plan of Care (POC)/CarePlanning Process as evidenced by signed statement of receipt by 6.12.25 For Patient #13, complete and successful medication reconciliation will becompleted by 6.12.25. LPN 2 will receiveadditional 1:1 education regarding medication reconciliation in accordance withPolicies CR-MA-002 Drug Regimen Review, TX-001 Physician Orders and MedicalSupervision of the Plan of Care and Policy AA-014 Plan of Care (POC)/CarePlanning Process as evidenced by signed statement of receipt by 6.12.25 For Patient #16, complete and successful medicationreconciliation will be completed by 6.12.25. RN 1 will receive additional 1:1 education regarding medicationreconciliation in accordance with Policies CR-MA-002 Drug Regimen Review, TX-001Physician Orders and Medical Supervision of the Plan of Care and Policy AA-014Plan of Care (POC)/Care Planning Process as evidenced by signed statement ofreceipt by 6.12.25 For Patient #14, complete and successful medication reconciliation will becompleted by 6.12.25. LPN 1 will receiveadditional 1:1 education regarding medication reconciliation in accordance withPolicies CR-MA-002 Drug	

	Patient should have a current medication list at home 1. A 12/19/2024 policy titled "Drug Regimen Review" indicated staff should review and ensure patients' medications are current and the comprehensive list of medications is updated any time there is a medication change. The agency must adhere to the most stringent regulations, including state, federal, and accreditation standards. The RN-Clinical Manager will review the patient's Medication Profile, as noted in their record/HCHB. A copy of the Medication profile is taken to the patient's home and placed in the patient's home folder, as well as incorporated into the medical record. 2. During a home visit at Entity 1 on 05/20/2025 at 9:00 AM, the Entity 1 nurse provided RN 2 with Patient #12's medication list. There was no medication list in Patient #12's room. RN 2 stated that they review medications at each visit; however, she took the medication list and left Entity 1 without reviewing and verifying		Physician Orders and MedicalSupervision of the Plan of Care and Policy AA-014 Plan of Care (POC)/CarePlanning Process as evidenced by signed statement of receipt by 6.12.25 Monitoringprocess: Administrator/Director of Operations, AlternateAdministrator, Clinical Manager, or Pod Peer Mentor of the agency willperform 15 total on-site in-home visits quarterly to be comprised of 5 visitseach for Parent and each Branch to assess compliance with Amedisys PoliciesCR-MA-002; TX-001, and AA-014 respectively until 100% compliance for medicationreconciliation with visits has been met x 2 quarters with a record kept offindings. This will continue to bemonitored as part of agency QAPI program review x 2 quarters. Administrator/Director of Operations, Alternate Administrator, Clinical Manager,or Area Vice President of Operations/Clinical of the	

	its accuracy or completeness. During an interview on 05/21/2025 at 12:15 PM, the Administrator and Area Care Manager reviewed all Patient records with the surveyors. The Administrator indicated that she was aware that the agency has an issue with medication reconciliation not being completed, and the home medication not being accurate with the agency's medication list. She indicated that the staff should complete a medication reconciliation every visit. 6. During a home visit on 05/20/2025 at 1:00 PM, RN 1 was unable to locate Patient #16's medication list at the home. RN 1 stated the Patient was to have a copy of the medication list. Patient #16 stated they never had a copy of the medication list.		patient charts weekly to ensure compliance with physician orders untiltarget threshold of 90% compliance is met. Once 90% compliance met x 2 weeks,will review 10% of active patient charts weekly until 100% compliance obtainedx 2 weeks. Once this threshold is met, we will continue to audit 10 recordsquarterly for compliance with QAPI process x 2 quarters. All education will be completed with active staff by 6.21.25.	
N0520	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be	N0520	**N0520 Patient Care** The administrator/Director of Operations will be responsible for correctingthis deficiency. All active and current agency	2025-06-21

	adequately met by the home health agency in the patient's place of residence. Based on record review and interview, the agency failed to meet the patients' health needs regarding blood sugar checks for 1 of 1 record reviews with blood sugar check orders. (Patient #16) Findings include: An 11/04/2024 policy titled "Physician Orders and Medical Supervision of the Plan of Care" indicated that staff provide care and services according to the physician's orders. Staff should obtain physician orders promptly. The agency will adhere to the most stringent regulations (state, federal, and accreditation). During a home visit on 05/20/2025 at 1:00 PM, Patient #16 stated that they had been out of lancets (needle-like tools used to prick the skin) for months, and the agency's SN was aware. Patient #16 stated they have not been able to test their blood sugar. They stated		and contract staff will receive trainingon the following policies/procedures and will be documented as evidenced bysign-in sheet: Policy AA-014 Plan of Care (POC)/Care PlanningProcess Policy TX-001 Physician Orders and MedicalSupervision of the Plan of Care Patient #16 will be reevaluated by registered nurse on 6.9.25 for plan ofcare update and intervention to assist patient with supplies procurement toensure diabetes management, monitoring, and safety according to physicianorders. Patient #16 will be educated regarding resources for procurement ofadditional diabetic testing supplies during registered nurse visit on 6.9.25and reinforced by clinical manager follow-up call 6.9.25.	

	the last blood sugar reading was in February of this year. Patient #16 stated the agency was working on getting a new physician for them. The agency failed to provide timely intervention to supply resources for diabetes management, monitoring, and safety. During an interview on 05/20/2025 at 1:20 PM, RN 1 stated this was the first visit she had with the patient. She stated she would look into it. A review of Patient #16's record, SOC date 02/24/2025, certification period 04/25/2025 to 06/23/2025, evidenced a POC indicating the physician ordered daily blood sugar testing and for the SN to assess and teach. The POC indicated to report abnormal findings of readings greater than 400 or less than 70. During an interview on 05/21/2025, at 3:00 PM, the Area Care Manager reviewed Patient #16's record. She stated that the agency had conducted ongoing discussions with the primary healthcare provider regarding the provision of lancets and other necessary supplies for blood glucose		RN1 will receive 1:1 education regarding Policies AA-014 Plan of Care(POC)/Care Planning Process and TX-001 Physician Orders and Medical Supervisionof the Plan of Care as evidenced by signed statement of receipt by 6.12.25 Monitoring Process: Administrator/Director of Operations, AlternateAdministrator, Clinical Manager, or Area Vice President of Operations/Clinical ofthe agency will audit 25% active patient charts weekly to ensure compliancewith plan of care until target threshold of 90% compliance is met. Once 90%compliance met x 2 weeks, will review 10% of active patient charts weekly until100% compliance obtained x 2 weeks. Once this threshold is met, we willcontinue to audit 10 records quarterly for compliance with QAPI process x 2 quarters. All education to be completed by 6.21.25	

	testing. The Care Manager indicated that these supplies have not been adequately available, which impedes the ability to obtain essential blood sugar readings. Without these measurements, assessing the patient's progress toward established health goals becomes challenging. She also emphasized the need for the agency to update the Plan of Care accordingly.			
N0522	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, licensed advanced practice registered nurse, licensed physician assistant, dentist, chiropractor, podiatrist, or an optometrist.	N0522	**N0522Patient Care** The administrator/Director of Operations will be responsible for correctingthis deficiency. All active and current agency and contract staff will receive training onthe following policies/procedures and will be documented as evidenced bysign-in sheet: Policy AA-014 Plan of Care (POC)/Care Planning Process PolicyTX-001 Physician Orders and Medical Supervision of the Plan of Care PolicyTX-002: Coordination of Care	2025-06-21

	Based on record review and interviews, the agency failed to have a signed POC or a verbal POC order from the primary physician before providing services and treatments to patients for 2 of 5 closed record reviews (Patients #4, #5) and for 6 of 12 active record reviews. (Patients #6, #7, #8, #10, #11, #14) Findings include: 2. A record review of Patient #4, certification period 04/24/2024 to 05/09/2024, revealed the agency provided patient care to Patient #4 without a detailed verbal order or physician-signed order received for visits 04/26/2024 and 04/27/2024. The agency failed to have orders before providing patient care. 3. A record review of Patient #5, certification period 01/02/2023 to 02/27/2023, revealed the agency provided patient care to Patient #5 without a detailed verbal order or physician-signed order received for visits 01/05/2023, 01/10/2023, 01/12/2023, 01/16/ 2023, 01/23/2023, 01/30/2023, and 02/06/2023. The agency failed		Patients#4 and #5 were closed record reviews and have discharged from agency prior tocorrection of deficiency. Patient #6had verbal order care coordination documentation to proceed with plan of careas discussed with MD obtained and documented medical record effective 6.5.25 Patient #7plan of care has been signed by physician as of 5.8.24 Patient #8plan of care has been signed by physician as of 5.29.25 Patient#10 plan of care has been signed by physician as of 5.6.25 Patient#11 plan of care has been signed by physician as of 4.23.25 Patient#14 plan of care has been signed by physician as of 4.28.25 Administrator/Directorof Operations, Alternate Administrator, Clinical	

	to have orders before providing patient care. 4. A record review of Patient #6, certification period 05/13/2025 to 07/11/2025, revealed the agency provided patient care to Patient #6 without a detailed verbal order or physician-signed order received for visits 05/15/2025, 05/16/2025, 05/19/2025, and 05/20/2025. The agency failed to have orders before providing patient care. 5. A record review of Patient #7, certification period 04/23/2025 to 06/21/2025, revealed the agency provided patient care to Patient #7 without a detailed verbal order or physician-signed order received for visits 04/24/2025, 04/28/2025, 05/01/2025, 05/05/2025, and 05/07/2025. The agency failed to have orders before providing patient care. 8. A record review of Patient #11, certification period 04/01/2025 to 05/30/2025, revealed the agency provided patient care to Patient #11 without a detailed verbal order or physician-signed order		will be educated by 6.12.25 regarding IDOH Newsletter 2023-03-12/13/2023Physician Coordination of Patient Plans of Care. Monitoring Process: Administrator/Director of Operations, Clinical Manager, or designee of theagency will audit 25% active patient charts weekly to ensure there is a verbalorder and physician communication documented showing approval of plan of care withinthe medical record until target threshold of 90% compliance is met. Once 90%compliance met x 2 weeks, will review 10% of active patient charts weekly until100% compliance obtained x 2 weeks. Once this threshold is met, we willcontinue to audit 10 records quarterly for compliance with QAPI process x 2quarters.	

	04/09/2025, and 04/16/2025. The agency failed to have orders before providing patient care. 9. A record review of Patient #14, certification period 04/07/2025 to 06/05/2025, revealed the agency provided patient care to Patient #14 without a detailed verbal order or physician-signed order received for visits 04/16/2025 and 04/25/2025. The agency failed to have orders before providing patient care. 10. During an interview on 05/21/2025 at 12:15 PM, the Administrator indicated she was not aware of the guidelines from the IDOH newsletter on having a signed POC or detailed verbal order. She confirmed the agency has not been obtaining a detailed verbal order from the physician of services the agency plans to provide until the signed POC is received. The Administrator indicated she did not have to review each chart with surveyors regarding this finding. 1. An 11/04/2024 policy titled "Physician Orders and Medical			

	indicated that staff provide care and services according to the physician's orders. Staff should obtain physician orders promptly. The agency will adhere to the most stringent regulations, including state, federal, and accreditation standards. 6. A review of Patient #8's records for the certification period from 03/11/2025 to 05/19/2025 evidenced that the agency provided patient care without obtaining a detailed verbal order or a physician-signed order for the visits on 03/11/2025, 03/15/2025, and 03/17/2025. The agency failed to secure these orders before delivering patient care. 7. A review of Patient #10's records for the certification period from 04/24/2025 to 06/22/2025 evidenced that the agency provided patient care without a detailed verbal order or a physician-signed order for the visits on 04/29/2025, 05/01/2025, 05/02/2025, and 05/05/2025. The agency failed to obtain these orders before administering patient care.			

	During an interview on 05/21/2025 at 1:10 PM, the Area Care Manager and the Administrator reviewed the records of Patients #8 and #10 with the surveyor. The Area Care Manager stated there would be no detailed verbal order of the care provided if the physician did not sign the POC. 11. During a home visit on 05/20/2025 at 1:00 PM, Patient #16 stated that they had been out of lancets (needle-like tools used to prick the skin) for months, and the agency's SN was aware. Patient #16 stated they have not been able to test their blood sugar. They stated the last blood sugar reading was in February of this year. Patient #16 stated the agency was working on getting a new physician for them. The agency failed to provide timely intervention to supply resources for diabetes management, monitoring, and safety. During an interview on 05/20/2025 at 1:20 PM, RN 1 stated this was the first visit she had with the patient. She stated she would look into it. A review of Patient #16's record,			

	SOC date 02/24/2025, certification period 04/25/2025 to 06/23/2025, evidenced a POC indicating the physician ordered daily blood sugar testing and for the SN to assess and teach. The POC indicated to report abnormal findings of readings greater than 400 or less than 70. During an interview on 05/21/2025, at 3:00 PM, the Area Care Manager reviewed Patient #16's record. She stated that the agency had conducted ongoing discussions with the primary healthcare provider regarding the provision of lancets and other necessary supplies for blood glucose testing. The Care Manager indicated that these supplies have not been adequately available, which impedes the ability to obtain essential blood sugar readings. Without these measurements, assessing the patient's progress toward established health goals becomes challenging. She also emphasized the need for the agency to update the Plan of Care accordingly.			

N0541	Scope of Services 410 IAC 17-14-1(a)(1)(B) Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on observation, record review, and interview, the agency staff failed to regularly review, reconcile, and provide accurate patient medication lists found in 7 of 7 home visits observed. (Patient #11, #12, #13, #14, #15, #16, #17) Findings include: 1. A 12/19/2024 policy titled "Drug Regimen Review" indicated that staff should review and ensure patients' medications are current and the comprehensive list of medications is updated whenever there is a medication change. The agency must adhere to the most stringent regulations, including state, federal, and accreditation standards. The RN-Clinical	N0541	**N0541Home Health Agency Scope of Services** The Administrator/Director of Operations will be responsible for correctingthis deficiency. All active clinical staff and management staff will receive training on thefollowing policies/procedures and will be documented as evidenced by sign-insheet: Policy CR-MA-002 Drug Regimen Review Policy TX-001 Physician Orders and Medical Supervision of the Plan of Care Policy AA-014 Plan of Care (POC)/Care PlanningProcess Education provided on 6.3.25 and 6.4.25 to parent and branch clinical staffregarding medication reconciliation. All clinical staff will receive new hire/annual competency and skillschecklists and annual on-site evaluation visits with medication reconciliationspecific education by 6.21.25 as evidenced in employee files and sign-in sheet.	2025-06-21

	Manager will review the patient's Medication Profile, as noted in their record/HCHB. The agency should place a copy of the medication profile in the patient's home folder and incorporate it into the medical record. 2. During an observation on 05/20/2025 at 1:05 PM, COTA reviewed Patient #11's medication list dated 05/01/2025 with the patient and found the following: Patient #11 has never taken Polyethylene Glycol in the home; their physician stopped Primidone, Sodium Chloride, and Tramadol over a month ago; all three were on the patient's medication list. Patient #11 takes Omeorzole but is not on the medication list. The patient's Gabapentin was changed from 3 times per day to 2 times per day by a physician over a month ago. A review of Patient #11's record includes a POC with a certification period of 04/01/2025 to 05/30/2025, which indicated orders for the agency to provide medication management, including		For Patient #12, complete and successful medication reconciliation will becompleted by 6.12.25. RN2 will receiveadditional 1:1 education regarding medication reconciliation in accordance withPolicies CR-MA-002 Drug Regimen Review, TX-001 Physician Orders and MedicalSupervision of the Plan of Care and Policy AA-014 Plan of Care (POC)/CarePlanning Process as evidenced by signed statement of receipt by 6.12.25 For Patient #13, complete and successful medication reconciliation will becompleted by 6.12.25. LPN 2 will receiveadditional 1:1 education regarding medication reconciliation in accordance withPolicies CR-MA-002 Drug Regimen Review, TX-001 Physician Orders and MedicalSupervision of the Plan of Care and Policy AA-014 Plan of Care (POC)/CarePlanning Process as evidenced by signed statement of receipt by 6.12.25 For Patient #16, complete and successful medication reconciliation will becompleted	

	medication review. During an interview on 05/20/2025 at 1:05 PM, COTA indicated staff had not gone through Patient #11's medication for a while since one of the medications the patient had not been on since being discharged from the hospital before being admitted to the agency. He indicated he usually doesn't review the medication bottles in the patient's home like he did during today's visit. 3.. MC 12 4. During an observation on 05/20/2025 at 11:35 AM, there was no evidence of a current medication list in Patient #13's home. LPN 2 failed to collect a current medication list from Entity 2 and reconcile medication during Patient #13's visit. During an interview on 05/20/2025 at 11:35 AM, LPN 2 indicated the agency requires a weekly medication reconciliation. 5. During an observation on 05/21/2025 at 10:50 AM, LPN 1 delivered a current medication list to Patient # 14 dated		receiveadditional 1:1 education regarding medication reconciliation in accordance withPolicies CR-MA-002 Drug Regimen Review, TX-001 Physician Orders and MedicalSupervision of the Plan of Care and Policy AA-014 Plan of Care (POC)/CarePlanning Process as evidenced by signed statement of receipt by 6.12.25 For Patient #11, complete and successful medication reconciliation will becompleted by 6.12.25. COTA will receiveadditional 1:1 education regarding medication reconciliation in accordance withPolicies CR-MA-002 Drug Regimen Review, TX-001 Physician Orders and MedicalSupervision of the Plan of Care and Policy AA-014 Plan of Care (POC)/CarePlanning Process as evidenced by signed statement of receipt by 6.12.25 For Patient #17, she is no longer an active patient of agency and agency wasunable to correct prior to discharge. For Patient #14, complete and successful medication reconciliation will becompleted by 6.12.25. LPN 1 will	

	05/19/2025. There was no prior medication list in the home. LPN 1 reviewed the 05/19/2025 medication list with Patient #14's caregiver and found that the Patient has been taking Hydrochlorothiazide (water pill) since 05/06/2025 (date on prescription). A record review of Patient #14 indicated that the Patient had a POC with a certification date of 04/07/2025 to 06/05/2025, which failed to evidence Hydrochlorothiazide on Patient #14's medication list. During an interview on 05/21/2025 at 12:10 PM, LPN 1 indicated the staff should reconcile medication at every visit. 6. During an observation on 05/21/2025 at 3:35 PM, OT reviewed Patient #15's medication list dated 05/19/2025 with the patient and found the following medications the patient is taking and are not on the medication list: Prednisone cream (reducing inflammation and suppressing the immune response), Oxycodone (pain), Tums (acid		receiveadditional 1:1 education regarding medication reconciliation in accordance withPolicies CR-MA-002 Drug Regimen Review, TX-001 Physician Orders and MedicalSupervision of the Plan of Care and Policy AA-014 Plan of Care (POC)/CarePlanning Process as evidenced by signed statement of receipt by 6.12.25 For Patient #15, complete and successful medication reconciliation will becompleted by 6.12.25. OT will receiveadditional 1:1 education regarding medication reconciliation in accordance withPolicies CR-MA-002 Drug Regimen Review, TX-001 Physician Orders and MedicalSupervision of the Plan of Care and Policy AA-014 Plan of Care (POC)/CarePlanning Process as evidenced by signed statement of receipt by 6.12.25 Monitoring process: Administrator/Director of Operations, Alternate Administrator Clinical Manager,or Pod Peer Mentor of the agency will perform 15 total	

	reflex), and Pyridium (UTI). During an interview on 05/21/2025 at 3:35 PM, Patient #15 indicated they had been on the Prednisone cream for years; the Pyridium dated December 2024. They were unsure of the start time for Oxycodone and Tums, but more than a month. During an interview on 05/21/2025 at 3:35 PM, OT 1 indicated that the last time he reviewed Patient #15 medication was over a month ago during evaluation. He indicated that staff should review medication at every visit, and each patient should have instructions for patients with updated medication lists. 6. mc 16 7. mc 17 8. During an interview on 05/21/2025 at 12:15 PM, the Area Care Manager indicated that the Patient should have a current medication list in the home. 9. During an interview on 05/21/2025 at 12:15 PM, the Administrator indicated she is		on-site in-home visitsquarterly to be comprised of 5 visits each for Parent and each Branch to assesscompliance with Amedisys Policies CR-MA-002; TX-001, and AA-014 respectivelyuntil 100% compliance for medication reconciliation with visits has been met x2 quarters with a record kept of findings. This will continue to bemonitored as part of agency QAPI program review x 2 quarters. b. Administrator/Director of Operations, Clinical Manager, or designee of theagency will audit 25% active patient charts weekly to ensure compliance withphysician orders until target threshold of 90% compliance is met. Once 90%compliance met x 2 weeks, will review 10% of active patient charts weekly until100% compliance obtained x 2 weeks. Once this threshold is met, we willcontinue to audit 10 records quarterly for compliance with QAPI process x 2quarters. All education will be completed with active staff by 6.21.25.	

	with the medication reconciliation not being completed and the home medication not being accurate with the agency's medication list. She indicated that the staff should complete a medication reconciliation every visit. Xx. During a home visit at Entity 1 on 05/20/2025 at 9:00 AM, the Entity 1 nurse provided RN 2 with Patient #12's medication list. There was no medication list in Patient #12's room. RN 2 stated that they review medications at each visit; however, she took the medication list and left Entity 1 without reviewing and verifying its accuracy or completeness. A review of Patient #12's medications showed that several, including Acidophilus (probiotic), Cyanocobalamin (vitamin B injection), Ondansetron (for nausea), Robitussin (cough), Sertraline (anti-depressant), Vitamin D3, Lasix (swelling), and Potassium (heart function), were not listed on the agency POC. The agency failed to ensure that staff reviewed the patient's medication list during each visit.			

	Xx. During a home visit on 05/20/2025 at 1:00 PM, RN 1 was unable to locate Patient #16's medication list at the home. RN 1 proceeded to review each medication bottle and compared the medications in the home with the list on her tablet. A review of Patient #16's medications showed that several, including Vitamin D3, Docusate Sodium (stool softener), Miralax (constipation), Oxycodone (pain), Potassium Chloride (heart) 20 milligrams (mg), Tamsulosin (urine frequency), Ventolin inhaler (asthma) were not correct according to the agency POC. During an interview on 05/20/2025 at 1:20 PM, Patient #16 stated that they have been taking Vitamin D2 since March, Potassium Chloride 10 gm since April, and Hydrocodone (for pain). They stated that they have been taking Benazepril (for blood pressure) and Tricor (to lower fatty acids) since March, as well as Tanaflex (for mood). Patient #16 stated that they have not taken Docusate Sodium, Lisinopril, Miralax, Oxycodone, or Tamsulosin since			

	February, and Ventolin because it is currently in storage. XX. During a home visit on 05/21/2025 at 9:00 AM, RN 4 reviewed Patient #17's medications in the home with the medication profile on her tablet. RN 4 found several of Patient #17's medications were not on the Agency's POC, including Biotin 1,000 milligrams (mg) (vitamin), Pantoprazole (to reduce stomach acid), and Vitamin B-12. During an interview on 05/21/2025 at 9:15 AM, Patient #17 stated they changed the Biotin dosage from 10,000 mg to 1,000 mg and take the Pantoprazole as needed instead of daily. Patient #17 stated they had taken Vitamin B-12 for two years. During an interview on 05/21/2025 at 9:20 AM, RN 4 stated nurses are to conduct medication reviews at each visit. She stated she did not know why the previous nurse had not updated the medication record. Xx. During an interview on 05/21/2025 at 1:30 PM, the Area Care Manager and			

	Administrator reviewed each patient record with the surveyors. The Administrator stated that the nurses should reconcile the patient medication list at each visit. She stated they have had education on this issue. The agency did not implement a comprehensive medication reconciliation process during home visits, resulting in incomplete or inaccurate medication documentation that poses potential safety risks for patients.			
N0545	Scope of Services 410 IAC 17-14-1(a)(1)(F) Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on observation, record review, and interview, the agency failed to coordinate services with other entities providing care services to the patients on 2 of 2 patients living in a facility. (Patient #12, #13), and 1 of 2 record reviews with	N0545	**N0545Home Health Agency Scope of Services** Theadministrator/Director of Operations will be responsible for correcting thisdeficiency. All activeclinical staff and management staff will receive training on the followingpolicies/procedures and will be documented and evidenced by sign-in sheet/attendance list: Amedisys form:Home Care/Assisted Living Facility-Coordination of Care note to	2025-06-21

	death in the home (Patient #4) Findings include: 1. A 05/22/2024 revised policy titled "Coordination of Care" indicates the agency should provide written instructions to include the treatment the patient will receive from the agency. The agency should Coordinate care with the patient, patient representative, and caregivers. 2. A review of Patient #4's record included a client Coordination Note Report dated 05/03/2024 that indicated PTA communicated with their Supervisor, Care Manager, LPN and Physical Therapist regarding Patient #4 complaining of a productive cough, patient not being able to tolerate a gait belt training or standing activity during PTA visit and the patient not feeling well. The record failed to evidence any further follow-up by agency staff. During an interview on 05/22/2025 at 8:35 AM, the Alternate Administrator reviewed Patient #4's record;		provide tofacility. Amedisysform: Verification of Non-Duplication of services-patient residing in anassisted living facility, group home, or personal care home. Policy:TX-002 Coordination of Care. Education completion date by 6.21.2025. Patients#12 and #13 will have agency communication binders in place at respectiveEntities 1 and 2 by 6.12.25 with collaboration instructions provided. All agencystaff will receive education by 6.21.25 as evidenced by sign-insheet/attendance list regarding Coordination of Care Binders at patient livingfacilities. MonitoringProcess: Administrator/Directorof Operations, Alternate Administrator, Clinical Manager, or Area VicePresident of Operations/Clinical will perform	

	she could not locate documentation of coordination care with a physician regarding the PTA coordination note on 05/03/2024; she indicated there should have been a coordination note and a follow-up call and visit made to Patient #4, with documentation by an RN. 3. MC 4. During an observation on 05/20/2025 at 11:35 AM, LPN failed to communicate with staff at Entity 2 regarding wound care to be provided to Patient #13 if wound dressing was to become soiled, wet, or removed before leaving the visit. During an interview on 05/20/2025 at 10:37 AM, the Qualified Medical Assistant for Entity 2 indicated she did not locate wound care orders in Entity 2's binder for Patient #13. She indicated wound care would be provided to Patient #13 by Entity 2 as needed. Still, the agency would be responsible for managing. She		audits on a total of 25% activepatient charts residing in an ALF, group home, or personal care home weekly toensure clear documentation showing care coordination between home health agencystaff and facility staff related to patient care needs until target thresholdof 90% compliance is met. Once 90% compliance met x 2 weeks, will review 10% ofactive patient charts weekly until 100% compliance obtained x 2 weeks. Oncethis threshold is met, we will continue to audit 10 records quarterly forcompliance with QAPI process times 2 quarters.	

	care instructions in Patient #13's room, which Entity 2 follows. She was unaware of any communication log between the agency and Entity 2. During an interview on 05/20/2025 at 11:35 AM, LPN 2 indicated she does not communicate with Entity 2 very often; if she does, it is with the receptionist, not to provide a report on the Patient. The LPN indicated that if wound care instructions were in Patient #13's room, they would be in the admission packet. The LPN confirmed the admission packet for Patient #13 did not have wound care instructions and no communication with Entity 2 5. During an interview on 05/21/2025 at 12:15 PM, the Administrator indicated agency staff are to communicate with other facility staff; Entity 2 should have a copy of current wound orders if they provide wound care when agency staff are not there. She also indicated that the staff document communication in the Patient's admission packet, that Entity 2's			

	staff should document when they provide wound care, and Entity 2 should have current wound care orders. 5. During an interview on 05/21/2025 at 12:15 PM, the Administrator indicated agency staff are to communicate with other facility staff; Entity 1 should have a copy of current wound orders if they provide wound care when agency staff are not there. She also indicated that the staff document communication in the Patient's admission packet, that Entity 1's staff should document when they provide wound care, and Entity 1 should have current wound care orders. 2. During a home visit at Entity 1 on 05/20/2025 at 9:00 AM, RN 2 discussed with the Entity 1 nurse the two new red areas on Patient #12's buttocks. The Entity 1 nurse stated she would get an order for Riley's Butt Cream (rash medication). Entity 1 nurse provided a list of medications for RN 2 to review; however, she did not review the medications at the visit. A review of Patient #12's record			

	Note Report dated 05/20/2025 that failed to indicate a discussion between RN 2 and Entity 1 nurse regarding Riley's Butt Cream. A review of Patient #12's record evidenced a treatment order dated 05/21/2025 for the SN to clean the wound in the coccyx area with normal saline, pat dry, and apply a foam dressing 3 days a week with the Entity 1 nurse to change it the other days. The record failed to evidence that the nurse notified Entity 1 of the order. During an interview on 05/21/2025 at 1:10 PM, the Clinical Manager and Administrator reviewed Patient #12's record. The Clinical Manager stated the nurse should document the coordination of care in the record. She was unsure why the nurse did not document a coordination note.			
N0547	Scope of Services 410 IAC 17-14-1(a)(1)(H) Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of	N0547	**N0547Home Health Agency Scope of Services** Theadministrator/Director of Operations will be responsible for correcting thisdeficiency. All	2025-06-21

	practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, licensed advanced practice registered nurse, licensed physician assistant, dentist, chiropractor, podiatrist, or optometrist orders (oral and written). Based on record review and interview, the registered nurse failed to follow the physician's orders for the frequency of lab collection for 1 of 1 records reviewed with lab orders. (Patient #7) Findings include: A 10/05/2023 revised document titled "Services Provided/Supervision of Disciplines -RN/LPN" indicates the RN/LPN should provide services as ordered by the physician. A review of Patient #7's record included the following: A POC certification Period from		active clinical staff and management staff will receivetraining on the following policies/procedures and will be documented andevidenced by sign-in sheet/ attendance list. Policy TX-001: Physician Ordersand Medical Supervision of the Plan of Care CorrectiveAction: All activeclinical staff received education regarding the above policies and procedures. Educationcompletion date 6.3.2025 and 6.4.2025 MonitoringProcess: Administrator/Directorof Operations/Clinical Manager/Agency Designee will perform audits on a totalof 25% active patient charts weekly to ensure compliance with physician orders untiltarget threshold of 90% compliance is met. Once 90% compliance met x 2 weeks,will review 10% of active patient charts weekly until 100% compliance obtainedx 2 weeks. Once this threshold is met, we will continue to audit 10 recordsquarterly for compliance with QAPI process times 2	

	04/23/2025 to 06/21/2025 indicates labs due weekly. A 05/07/2025 physician order indicates labs are due every other week. A 05/08/2025 Client Coordination Note Report indicates "order for labs was misunderstood, no new lab orders at this time. continue same labs and frequency until new orders obtained". During an interview on 05/22/2025 at 8:35 PM, the Alternate Administrator reviewed Patient #7's record and confirmed no physician order to return lab frequency to weekly. The current order is for every other week. Still, the agency collects labs weekly on Patient #7 without an order.		quarters.	
N0558	Scope of Services 410 IAC 17-14-1(a)(2)(F) Rule 14 Sec. 1(a) (2)(F) For purposes of practice in the home health setting, the licensed practical nurse shall do the following:	N0558	**N0558Home Health Agency Scope of Services** Theadministrator/Director of Operations will be responsible for correcting thisdeficiency. All active clinical staff and management staff will receivetraining by 6.21.25 on the following policies/procedures and will be	2025-06-21

	(F) Accept and carry out physician, licensed advanced practice registered nurse, licensed physician assistant, dentist, chiropractor, podiatrist, or optometrist orders (oral and written). Based on observation, record review, and interview, the LPN failed to provide patient care as ordered by the physician on 2 of 2 LPN home visit observations. (LPN 1, LPN 2) Findings include: 1. A 03/17/2025 revised policy titled "Medication Administration" indicates a physician order is required for agency staff to prefill medication planners. 2. A 10/05/2023 revised document titled "Services Provided/Supervision of Disciplines -RN/LPN" indicates the RN/LPN should provide services as ordered by the physician. 3. During an observation on 05/20/2025 at 11:35 AM, LPN 2 provided wound care to Patient		documentedand evidenced by sign-in sheet/ attendance list. Policy MA-001: MedicationAdministration Policy TX-001: Physician Ordersand Medical Supervision of the Plan of Care Policy WC-001: The Provision ofWound and Skin Care MonitoringProcess: Administrator/Directorof Operations, Alternate Administrator, Clinical Manager, or Area VicePresident of Operations/Clinical will perform audits on a total of 25% activepatient charts weekly to ensure compliance with physician orders until targetthreshold of 90% compliance is met. Once 90% compliance met x 2 weeks, willreview 10% of active patient charts weekly until 100% compliance obtained x 2weeks. Once this threshold is met, we will continue to audit 10 recordsquarterly for compliance with QAPI process times 2 quarters.	

	wound with wound cleanser, applying dry Prisma (a sterile, freeze-dried wound dressing composed of oxidized regenerated cellulose (ORC), collagen, and silver-ORC), Bactroban (antibacterial used to treat skin infections), bordered dressing and offloading foam. LPN 2 failed to follow the current physician's orders when providing wound care to Patient #13, and the agency failed to follow the physician's wound care frequency order. A record review of Patient #13 includes a Visit Report dated 05/08/2025 from the wound healing center with orders that indicates the agency should provide wound care to the left foot by cleansing the wound, patting dry, applying Mupirocin (a topical antibiotic used to treat bacterial skin infections) to the base of the wound, moisten Prisma, apply skin prep to pert wound cover with bordered dressing, to be changed 3 times per week. During an interview on 05/20/2025 at 11:35 AM, LPN 2 indicated she provided wound			

	was unaware of other wound care orders. The LPN indicated Patient #13 is seen twice per week by the agency; she confirmed the order indicates 3 times per week and does not know why the agency is not providing the third visit. During an interview on 05/21/2025 at 12:15 PM, the Area Clinical Manager and the Administrator reviewed Patient #13's record. The area clinical manager confirmed that the wound care order on 05/08/2025 indicates that the agency's wound care order is for 3 times per week; she also confirmed that LPN 2 should have followed the wound orders from 05/08/2025 during the observation visit on 05/20/2025, not the old POC orders. The Administrator agreed. 4. During an observation on 05/21/2025 at 10:50 AM, LPN 1 filled Patient #14's medication planner. LPN 1 failed to obtain orders to manage Patient #14's medication. A review of Patient #14's record included a POC with a certification period of			

	failed to evidence an order for skilled nursing to set up a medication planner. During an interview on 05/21/2025 at 12:10 PM, LPN 1 indicated an order is needed for the staff to fill a patient's medication planner. During an interview on 05/21/2025 at 12:10 PM, the Administrator indicated that Patient #14 should have had a physician order for staff to fill the Patient's medication planner.			
N0608	Clinical Records 410 IAC 17-15-1(a)(1-6) Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.	N0608	**N0608Home Health agency Clinical records** Theadministrator/Director of Operations will be responsible for correcting thisdeficiency. All active clinical staff and management staff will receivetraining on the following policies/procedures by 6.21.25 and will be documentedand evidenced by sign-in sheet/ attendance list. Policy AA 016: Discharge ofPatients	2025-06-21

	(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interview, the agency failed to notify the primary physician of patient discharge from the home health agency on 1 of 2 discharged records reviewed due to death. (Patient # 3) Finding includes: A 10/10/2024 revised policy titled "Discharge of Patients" indicates the agency will notify the patient's physician of the patient's discharge from the home health agency. A review of Patient #3 record failed to evidence the agency had sent a discharge summary to the primary physician.		MonitoringProcess: Administrator/Directorof Operations/Clinical Manager/Agency Designee will perform audits viaevaluation of the discharged patient report as it compares to the fax statusreport to ensure discharge summaries were successfully faxed to thephysician/provider within 5 days of discharge until target threshold of 100%compliance is met x 2 weeks. Once the threshold is met, we will continue toaudit 10 records quarterly for compliance with QAPI process x 2 quarters.	

	During an interview on 05/22/2025 at 8:35 AM, the Alternate Administrator reviewed Patient #3's record. She could not locate proof that the agency had notified Patient #3's physician of discharge from the agency.			
N9999	Final Observations Authority IC 16-27-1.5-5 "Approved dementia training for home health aides" Sec. 5 (a) This section applies to a registered home health aide who: (1) is employed as a home health aide; and (2) provides care to an individual who has been diagnosed with or experiences symptoms of Alzheimer's disease, dementia, or a related cognitive disorder. (b) As used in this section, "approved dementia training" refers to a dementia training program: (1) for use in training home health aides in the care of individuals described in subsection (a)(2); and (2) that has been approved by the state department under subsection (f). (c) Not later than sixty (60) days after the date on which a home health aide is initially hired to care for an individual with Alzheimer's disease, dementia, or a related cognitive disorder, the home health aide shall complete at least six (6) hours of approved dementia training. (d) Before December 31 of each year, a home health aide who has been employed as a home health aide for at least one (1) year shall complete at least three (3) hours of approved dementia training.	N9999	**N9999Final Observations** The administrator/Director of Operations or designee will be responsible forcorrecting this observation. Provider immediately reviewed training records and identified home healthaide requiring revised dementia training. Home health aid was promptly enrolled in an ISDH-approved dementia caretraining program. Training to be completed by 6.21.2025. Documentation of completion certificate/attendance sheet will be placed inhome health aide personnel file upon completion of ISDH—approved dementia caretraining program. Provider has partnered with an ISDH-recognized dementia training provider toensure	2025-06-21

	(e) A home health aide who: (1) has received the training required by subsections (c) and (d); (2) has been employed as a home health aide for at least twenty-four (24) consecutive months; and (3) is hired by a home health agency; is not required to repeat the training required by this section. (f) The state department shall do the following: (1) Identify and approve each dementia training program that meets the following requirements: (A) The dementia training program includes education concerning the following: (i) The nature of Alzheimer's disease, dementia, and other related cognitive disorders. (ii) Current best practices for caring for and treating individuals with dementia. (iii) Guidelines for the assessment and care of an individual with dementia. (iv) Procedures for providing patient centered quality care. (v) The daily activities of individuals with dementia. (vi) Dementia related behaviors, communication, and positive intervention. (vii) The role of an individual's family in caring for an individual with dementia. (B) The dementia training program: (i) must be culturally competent; and (ii) may be provided online. (2) Establish and implement a process for state department approval of a dementia training program. (g) To the extent allowed by 42 CFR 484.80, the hours of approved dementia training completed under this section satisfies an equivalent number of hours of the home health aide training required by 42 CFR 484.80.		availability and tracking of approved dementia training content. Monitoring Process: Administrator/Director of Operations, Clinical Manager, or designee of theagency will perform an audit of 100% of home health aide personnel filesmonthly for 6 months for 100% compliance with Observation N9999 CFR (s): IC16-27-1.5 “Approved dementia training for home health aides”. Home health aidepersonnel files will continue to be audited quarterly from parent and branchesand as part of regular QAPI process x 2 quarters. All education to be completed by 6.21.25	

(h) An entity that provides approved dementia training shall provide to each home health aide who successfully completes the training a certificate of completion.

(i) A home health aide:

(1) is responsible for maintaining the home health aide's certificate of completion; and

(2) may use the certificate of completion as proof of compliance with this section.

As added by P.L.44-2022, SEC.1.

Authority IC 16-27-1.5-6 "Conditions required to administer gastrointestinal and jejunostomy tube feedings; training"

Sec. 6 (a) A registered home health aide may administer gastrointestinal and jejunostomy tube feedings to a specific patient only if the following conditions are met:

(1) The registered home health aide has completed the training curriculum described in subsection (b).

(2) A registered nurse, providing registered nursing under IC 25-23-1-1.1(b)(6), either:

(A) supervises the registered home health aide in administering the gastrointestinal and jejunostomy tube feedings; or

(B) delegates responsibility for administering the gastrointestinal and jejunostomy tube feedings to the registered home health aide based on the registered nurse's assessment of the registered home health aide's competency to administer gastrointestinal and jejunostomy tube feedings.

(3) The home health agency that the registered home health aide is employed with:

(A) allows the registered home health aide to administer gastrointestinal and jejunostomy tube feedings;

(B) establishes a procedure for:

(i) the delegation of the administration of

from a registered nurse to a registered home health aide that includes patient specific clinical parameters based on the registered nurse's assessment of the patient and the registered home health aide's competency to administer the gastrointestinal and jejunostomy tube feedings; and

(ii) the assessment by the registered nurse of the patient specific clinical parameters;

(C) retains documentation that the registered home health aide has completed the training curriculum described in subsection (b); and

(D) notifies each patient requiring gastrointestinal and jejunostomy tube feedings upon admission that the home health aide agency may allow registered home health aides to administer gastrointestinal and jejunostomy tube feedings.

(b) Training curriculum for home health aides to administer gastrointestinal and jejunostomy tube feedings must:

(1) be approved by the state department; and

(2) include the following concerning the administration of gastrointestinal and jejunostomy tube feedings:

(A) At least four (4) hours and not more than eight (8) hours of classroom training.

(B) At least two (2) hours and not more than four (4) hours of practical training.

(C) A written and practical examination administered by the trainer.

(c) A registered home health aide may not administer gastrointestinal and jejunostomy tube feedings until the home health aide has successfully:

(1) completed the curriculum described in subsection (b); and

(2) passed the examinations described in subsection (b)(2)(C).

(d) The state department may require a registered home health aide who administers gastrointestinal and jejunostomy tube feedings under this section to annually complete not

specific to the administration of gastrointestinal and jejunostomy tube feedings.

(e) Before January 1, 2024, the state department must approve at least one (1) training curriculum described in subsection (b).

As added by P.L.117-2023, SEC.6.

Sec. 5. (a) This section applies to a registered home health aide who:

(1) is employed as a home health aide; and

(2) provides care to an individual who has been diagnosed with or experiences symptoms of Alzheimer's disease, dementia, or a related cognitive disorder.

(b) As used in this section, "approved dementia training" refers to a dementia training program:

(1) for use in training home health aides in the care of individuals described in

subsection (a)(2); and

(2) that has been approved by the state department under subsection (f).

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

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

(e) A home health aide who:

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

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

(3) is hired by a home health agency;

is not required to repeat the

	training required by this section. (f) The state department shall do the following: (1) Identify and approve each dementia training program that meets the following requirements: (A) The dementia training program includes education concerning the following: (i) The nature of Alzheimer's disease, dementia, and other related cognitive disorders. (ii) Current best practices for caring for and treating individuals with dementia. (iii) Guidelines for the assessment and care of an individual with dementia. (iv) Procedures for providing patient-centered quality care. (v) The daily activities of individuals with dementia. (vi) Dementia-related behaviors, communication, and positive intervention.			

	(vii) The role of an individual's family in caring for an individual with dementia. (B) The dementia training program: (i) must be culturally competent; and (ii) may be provided online. (2) Establish and implement a process for state department approval of a dementia training program. (g) To the extent allowed by 42 CFR 484.80, the hours of approved dementia training completed under this section satisfies an equivalent number of hours of the home health aide training required by 42 CFR 484.80. (h) An entity that provides approved dementia training shall provide to each home health aide who successfully completes the training a certificate of completion. (i) A home health aide:			

(1) is responsible for maintaining the home health aide's certificate of completion; and

(2) may use the certificate of completion as proof of compliance with this section.

This LICENSURE REQUIREMENT is NOT MET as evidenced by:

Based on record review and interview, the agency failed to ensure the agency's dementia program and training were conducted under an approved program by the Indiana Department of Health (IDOH) for 1 of 1 dementia program review, with the potential to affect all active home health aides. (HHA #1)

Findings include:

According to Indiana Code 16-27-1.5-5, the Indiana Department of Health (IDOH) must approve the Agency's dementia training program under subsection f.

A review of HHA 1's personnel record indicated that she completed a monthly one-hour

	In-Service on providing knowledge, strategies, and skills needed to care for patients with Alzheimer's in January, February, March, and April 2024, as well as for March and April 2025. During an interview on 05/22/2025 at 11 AM, the Alternate Administrator stated HHA 1 has taken care of patients with dementia and Alzheimer's disease in the past. She stated she has been through training. An email received on 05/22/2025, from the Administrator, after exiting, indicated that the Office of Dementia Services approved the Dementia Curriculum and meets the regulatory requirements of Kentucky Revised Statutes (KRS) 216.710/KRS 216.935. The agency failed to meet the core requirement that the curriculum was approved by the IDOH or conducted under an approved Indiana program.			

Jama Beyers	Administrator/Director of Operations	6/6/2025 2:25:57 PM