STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCROGGINS NURSING AND HOME SERVICES INC	8525 SW JENNINGS ST, COMMISKEY, IN, 47227

(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: 06/04/2025 - 06/06/2025 and 06/09/2025 - 06/10/2025 Active Census: 15 At this Emergency Preparedness survey, Scroggins Nursing & Home Care was not found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR §484.102.	E0000	E-0000 Agency was cited for not having implemented an Emergency Preparedness Plan using an all-hazards approach. Our Emergency Preparedness Plan currently was not using this approach. Our office sought the assistance of a consulting firm to assist with creating the correct Emergency Preparedness Plan using all hazards approach in order to get it completed within the short timeframe. It will be uploaded with new policy and procedure to be completed by 8/6/25 by DON.	
E0001	Establishment of the Emergency Program (EP) 483.73	E0001	E0001	2025-06-24

	§403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:		Agency was cited for not having implemented an Emergency Preparedness Plan using an all-hazards approach. Our Emergency Preparedness Plan currently was not using this approach. Our office sought the assistance of a consulting firm to assist with creating the correct Emergency Preparedness Plan using all hazards approach in order to get it completed within the short timeframe. It will be uploaded with new policy and procedure to be completed by 8/6/25 by DON.	

	Based on record review and interview, the agency failed to develop and maintain an individualized Emergency Preparedness Plan for 1 of 1 agency reviewed with the potential to affect all patients. Findings include: Review of a binder provided by the agency on 06/10/2025, evidenced forms related to Emergency Preparedness. Review of a document titled "Agency Profile" was filled out with basic demographic information and a document titled "Outpatients in Care" was filled out and the signature page indicated the form was last signed on 10/01/2022. The remaining forms and paperwork in the binder were not filled out or individualized to the agency. During an interview on 06/09/2025, the BOM (Business Office Manager) indicated being unsure if the agency has an Emergency Preparedness program. During an interview on 06/10/2025 at 10:03 AM, the DON (Director of Nursing) indicated being unsure of what an Emergency Preparedness plan for the agency would consist of since she recently had taken over the DON position. She provided a binder of what previous staff had started to put together and indicated she would work to correct the issues now that she is aware of them			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider.	G0000		

	Survey Dates: 06/04/2025 - 06/06/2025 and 06/09/2025 - 06/10/2025 12-Month Unduplicated Skilled Admissions: 1 Partially Extended on 06/06/2025 at 1:03 PM Fully Extended on 06/10/2025 at 11:30 AM This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Abbreviations: RN Registered Nurse LPN Licensed Practice Nurse HHA Home Health Aide POC Plan of Care SOC Start of Care QAPI Quality Assurance and Performance Improvement OASIS Outcome and Assessment Information Set			
G0414	HHA administrator contact information 484.50(a)(1)(ii) (ii) Contact information for the HHA administrator, including the administrator's name, business address, and business phone	G0414	G0414 All start of care folders will be updated with the Administrator and DON's name, business address and contact information on the booklets. All current patient's home folders will be provided with an updated sheet with Administrator and DON's name, business address and contact information. All clinicians will be provided education on educating	2025-06-16

	number in order to receive complaints. Based on record review and interview, the agency failed to furnish the patient or patient's legal representative with contact information for the home health administrator, including: the administrator's name, business address, and business phone number for the purpose of receiving complaints for 3 of 4 home visits conducted (Patient #1, #4, #6). Findings include: 1. During a home visit with Patient #6 on 06/05/2025 at 3:25 PM, a review of the patient's folder provided by the agency, failed to evidence patient was informed of the name and contact information for the home health administrator. During an interview on 06/05/2025 at 3:25 PM, Patient #6 indicated being unsure of who the Administrator and Clinical Manager of the agency are. Patient #6 indicated being unaware of their contact information. 2. During a home visit with Patient #3 on 06/06/2025 at		patients on the Administrator and DON's name, business address, and contact information via an in-service. This will be completed by 8/6/25 and completeness will be tracked by the Administrator. Home visits will be conducted within 2 weeks of admission with DON for all admissions monthly to check home folders for missing Administrator, DON and hotline numbers until 95% of charts are compliant for three consecutive months. An updated policy and procedure regarding providing required information to all patients will be completed in one month. Policy and procedure to be completed by 8/6/25.	

	7:30 AM, a review of the patient's folder provided by the agency, failed to evidence patient was informed of the name and contact information for the HHA administrator. 3. During a home visit with Patient #1 on 06/09/2025 at 9:30 AM, a review of the patient's folder provided by the agency, failed to evidence patient was informed of the name and contact information for the HHA administrator. 4. During an interview on 06/06/2025 at 3:10 PM, the DON and BOM (Business Office Manager) indicated they were unaware of the requirement for written instructions informing patients/caregivers of the HHA clinical manager name and contact information, be provided to patients by the agency. The DON indicated she was unsure if they have a policy related to the requirement.			
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content.	G0564	G-0564 All discharges will provide to the primary physician or receiving facility the patient's 485 as well as a summary to specifically address all medical information concerning the patient's current condition of illness and treatment, after discharge goals of care, and treatment choices to guarantee the safe and effective	2025-06-24

	The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the agency failed to ensure a discharge summary containing: all essential medical information concerning the patient's current condition of illness and treatment, after discharge goals of care, and treatment choices was provided to their primary care provider to guarantee the safe and effective change in care for 2 of 2 closed records reviewed (Patient #9, #10). Findings include: 1. Review of a policy titled "Completion of Discharge Summary," indicated but was not limited to: "The agency will complete a discharge summary for each client discharged from the agency. A copy of the discharge summary will be made available to the client's physician. The copy may be mailed or faxed to the physician &The top portion on the DC summary shall be completed if it was not completed at the time of admission &The		transition of care. All clinicians will be educated on sending all necessary medical information pertaining to the patient's current course of illness and treatment, post discharge goals of care and treatment preferences to the receiving facility or primary physician to ensure the safe and effective transition of care via in-service. This will be completed by 8/6/25 with updated policy and procedure. The office manager and DON will track all discharges and audit charts quarterly to ensure 100% compliance in one month.	

	completion of these forms shall be placed in the clinical record &" 2. The clinical record for Patient #9, benefit period 06/29/2024 - 08/27/224, evidenced a discharge date of 07/25/2024 and a discharge order signed by the patient's primary physician on 08/29/2024. The record failed to evidence a discharge summary was created for the patient and provided to their primary care provider. 3. The clinical record for Patient #10, benefit period 06/08/2024 - 08/06/2024, evidenced a discharge date of 07/26/2024 and a discharge order signed by the patient's primary physician on 08/09/2024. The record failed to evidence a discharge summary was created for the patient and provided to their primary care provider. 4. During an interview on 06/10/2025 at 10:20 PM, the DON and BOM (Business Office Manager) indicated the agency does not currently send discharge summaries to patients' physicians at discharge; the agency reaches out to physician to obtain an			

	order for discharge upon patient's discharge. They indicated the majority of their patients discharge unexpectedly due to loss of payor source approval.			
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;	G0574	G-0574 All current patient's plan of care will be updated to include psychosocial and cognitive status, a description of patient's risk of ER visits or hospital readmissions and any interventions to address the underlying risk, patient and caregiver education and training to facilitate discharge, patient and caregiver identified goals, measurable outcomes and education to reach goals. All clinicians will be educated on adding to each plan of care with psychosocial and cognitive status, a description of patient's risk of ER visits or hospital readmissions and any intervention to address the underlying risk, patient and caregiver education and training to facilitate discharge, patient and caregiver identified goals, measurable outcomes and education to reach goals via in-service. Clinicians will	2025-06-24

	(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the agency failed to ensure POCs included personalized patient and caregiver training and education to promote an efficient discharge; patient/caregiver identified goals, measurable outcomes, interventions, and education to reach goals; and an explanation of the patient's likelihood for emergency department visits and hospital re-admission for 10 of 10 patients' records reviewed (Patient #1, #2, #3, #4, #5, #6, #7, #8, #9, #10). Findings include: 1. A review of a policy titled "Medical Plan of Care", indicated but was not limited to: "The medical plan of care shall be developed in consultation with the home health agency staff and shall cover all pertinent diagnoses and include the following: Any other appropriate items &"		address these additions at each visit and update the plan of care as needed. This will be completed by 8/6/25 with an updated policy and procedure to update all information needed on each care plan. DON will address each monthly plan of care with supervisory visits. Quarterly chart audits will continue to be conducted by 3 separate staff to ensure 100% compliance in one month.	

	2. The clinical record for Patient #1, benefit period 05/12/2025 - 07/10/2025, evidenced the POC failed to include personalized patient and caregiver training and education to promote an efficient discharge; patient/caregiver identified goals, measurable outcomes, interventions, and education to reach goals; and an explanation of the patient's likelihood for emergency department visits and hospital re-admission. 3. The clinical record for Patient #2, benefit period 05/13/2025 - 07/11/2025, evidenced the POC failed to include personalized patient and caregiver training and education to promote an efficient discharge; patient/caregiver identified goals, measurable outcomes, interventions, and education to reach goals; and an explanation of the patient's likelihood for emergency department visits and hospital re-admission. 4. The clinical record for Patient #3, benefit period 05/25/2025 - 07/23/2025, evidenced the POC failed to include personalized patient and caregiver training and education to promote an efficient discharge;			

	patient/caregiver identified goals, measurable outcomes, interventions, and education to reach goals; and an explanation of the patient's likelihood for emergency department visits and hospital re-admission. 5. The clinical record for Patient #4, benefit period 05/18/2025 - 07/16/2025, evidenced the POC failed to include personalized patient and caregiver training and education to promote an efficient discharge; patient/caregiver identified goals, measurable outcomes, interventions, and education to reach goals; and an explanation of the patient's likelihood for emergency department visits and hospital re-admission.			

	6. The clinical record for Patient #5, benefit period 04/10/2025 - 06/08/2025, evidenced the POC failed to include personalized patient and caregiver training and education to promote an efficient discharge; patient/caregiver identified goals, measurable outcomes, interventions, and education to reach goals; and an explanation of the patient's likelihood for emergency department visits and hospital re-admission. 7. The clinical record for Patient #6, benefit period 05/24/2025 - 07/22/2025, evidenced the POC failed to include personalized patient and caregiver training and education to promote an efficient discharge; patient/caregiver identified goals, measurable outcomes, interventions, and education to reach goals; and an explanation of the patient's likelihood for emergency department visits and hospital re-admission. 8. The clinical record for Patient #7, benefit period 05/24/2025 - 07/22/2025, evidenced the POC failed to include personalized patient and caregiver training and education to promote an efficient discharge;			

	patient/caregiver identified goals, measurable outcomes, interventions, and education to reach goals; and an explanation of the patient's likelihood for emergency department visits and hospital re-admission. 9. The clinical record for Patient #8, benefit period 04/09/2025 - 06/07/2025, evidenced the POC failed to include personalized patient and caregiver training and education to promote an efficient discharge; patient/caregiver identified goals, measurable outcomes, interventions, and education to reach goals; and an explanation of the patient's likelihood for emergency department visits and hospital re-admission. 10. The clinical record for Patient #9, benefit period 06/29/2024 - 08/27/2024, evidenced the POC failed to include personalized patient and caregiver training and education to promote an efficient discharge; patient/caregiver identified goals, measurable outcomes, interventions, and education to reach goals; and an explanation of the patient's likelihood for			

	and hospital re-admission. 11. The clinical record for Patient #10, benefit period 06/08/2024 - 08/06/2024, evidenced the POC failed to include personalized patient and caregiver training and education to promote an efficient discharge; patient/caregiver identified goals, measurable outcomes, interventions, and education to reach goals; and an explanation of the patient's likelihood for emergency department visits and hospital re-admission. 12. During an interview on 06/05/2025 at 2:36 PM, the DON acknowledged the POCs for all agency patients do not contain patient/caregiver specific education and training to meet goals for discharge in relation to identified measurable goals and interventions, emergency department/re-admission risk, or patient/caregiver training/education for a timely discharge. She indicated being unaware of the requirement due to being new to her role and will work to fix the issues now that she is aware.			

	410 IAC 17-13-1(a)(1)(C)(xi) 410 IAC 17-13-1(a)(1)(C)(xiii)			
G0576	All orders recorded in plan of care 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. Based on record review and interview, the agency failed to ensure all doctor's orders were included on the POC for 1 of 2 skilled home visits conducted (Patient # 3). Findings include: Review of a policy titled "Medical Plan of Care," indicated but was not limited to: "The medical plan of care shall be developed in consultation with the home health agency staff and shall cover all pertinent diagnoses and include the following: Nutritional requirements &Medications and treatments &" The clinical record for Patient #3, benefit period 05/25/2025 - 07/23/2025, evidenced a POC with a section listed as "16. Nutritional Req: GT 30 mL Q 4hr	G0576	G 0576 All patient care orders including verbal orders will be recorded accurately in the plan of care for each client. Plan of care for patient #3 SECTION 16 NUTRITION was updated to clearly state physician order of g-tube feedings of four feedings daily of Nourish Peptide Formula Complete that comes in 32 fluid oz bag and divided up in to bottles with 6 oz each combined with 2 oz of water and is run on the Infinity pump at a rate of 250ml/hr with 30ml of H2O to flush when the feed is complete. All clinicians will be educated on accurate physician orders including verbal orders to be accurate, as well as what should be included for the orders to be complete on client plan of care via in-service. This will be completed by 8/6/25 by DON in include updated policy and procedure for completing physician order details on plan of care. This will be reviewed at monthly supervisory visits by DON for any updates or physician order changes if needed. This will be tracked by DON and Business Manager with quarterly chart audits of every patient to assure a goal of 100% accuracy and compliance within one month.	2025-06-24

	treatment/nutrition order. The order failed to indicate the type, amount, and rate to administer for the feeding. During a home visit on 06/06/2025 at 7:30 AM, RN 2 was prepared to administer the G-tube (short for gastrostomy tube that is essentially a soft, flexible tube inserted through the skin of your abdomen directly into your stomach for feedings when unable to eat by mouth) feeding for Patient #3 with an Infinity Pump. RN 2 indicated the patient received four (4) feedings daily of Nourish Peptide formula (complete) that comes in a 32 fluid ounce bag and is divided up into bottles with 6 ounces each combined with two (2) ounces of water and is run on the Infinity pump at a rate of 250 milliliters (mL) an hour with 30 mL of water to flush when the feed was complete. RN 2's administration failed to match the order on the POC for the nutritional requirement. During an interview on 06/06/2025 at 7:30 AM, RN 2 indicated not being aware the complete order was not on the POC and what the patient was			

	supposed to be given and what was administered. During an interview on 06/06/2025 at 3:20 PM, the DON indicated the order for nutritional requirement treatment was not complete on Patient #3's POC. She indicated the order was missing the formula type and the rate of administration for the formula were not included as they should be in order for the order to be complete.			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on record review and interview, the agency failed to ensure all patients received a schedule with frequency of visits and by what service type for 3 of 4 home visits conducted (Patients #1, #3, and #6). Findings include: 1. During a home visit with Patient #6 on 06/05/2025 at 3:25 PM, a review of the patient's folder provided by the agency, failed to evidence a visit schedule of services to be provided by the agency and who would be	G0614	G0614 All patients of the agency will be provided with a visit schedule to include the frequency of visits by HHA or personnel acting on behalf of the HHA and what services will be provided. Patients will be provided with HHA care plans. Patients will be educated on the agency providing visit schedule and HHA to keep in folder. Education will be provided to all clinicians with the importance of providing the patient with the name of HHA as well as schedule and services to be provided via the in-service. This will be completed by 8/6/25 by DON with updated policy and procedure. This will be tracked by checking at monthly supervisory visits for a goal of 100% compliance within one month. Policy and procedure will be created by 8/6/25.	2025-06-24

	providing the services. 2. During a home visit with Patient #3 on 06/06/2025 at 7:30 AM, a review of the patient's folder provided by the agency, failed to evidence a visit schedule of services to be provided by the agency and who would be providing the services. 3. During a home visit with Patient #1 on 06/09/2025 at 9:30 AM, a review of the patient's folder provided by the agency, failed to evidence a visit schedule of services to be provided by the agency and who would be providing the services. 4. During an interview on 06/05/2025 at 3:40 PM, HHA 1 indicated the DON just brought a new folder to the home and told her to put it somewhere they could easily locate it. She indicated there is no aide plan of care, schedule of visits patient should receive, medication list present in the folder. 5. During an interview on 06/06/2025 at 3:10 PM, the DON and BOM indicated they were unaware of the requirement for a written visit schedule to be provided to patients by the agency. The DON indicated she was unsure if they have a policy related to the requirement. 410 IAC 17-12-3(b)(2)(D)(i) 410 IAC 17-12-3(b)(2)(D)(i)			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and	G0616	G-0616 All patients will be provided with a current medication list in the home to include medication name, dosage, frequency and instructions/schedule. All patients will be provided with which medications will be administered by the RN or personnel acting on	2025-06-24

	frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on record review and interview, the agency failed to ensure all patients received a current written medication list for 4 of 4 home visits conducted (Patients #1, #3, #4, and #6). Findings include: 1. During a home visit with Patient #6 on 06/05/2025 at 3:25 PM, a review of the patient's folder provided by the agency, failed to evidence a complete list of current medications prescribed. 2. During a home visit with Patient #3 on 06/06/2025 at 7:30 AM, a review of the patient's folder provided by the agency, failed to evidence a complete list of current medications prescribed. 3. During a home visit with Patient #4 on 06/06/2025 at 12:17 PM, a review of the patient's folder provided by the agency, failed to evidence a complete list of current medications prescribed. 4. During a home visit with Patient #1 on 06/09/2025 at 9:30 AM, a review of the patient's folder provided by the agency, failed to evidence a complete list of current medications prescribed. 5. During an interview on 06/05/2025 at 3:40 PM, HHA 1 indicated the DON recently brought a new folder to the home and told her to put it somewhere they could easily locate it. She indicated there is no aide plan of care, schedule of visits patient should receive, medication list present in the folder.		their behalf. Education will be provided to all clinicians on the importance of verifying current medication list is in the home via in-service. All patients will be educated that a current medication list will be provided by the patient at SOC and updated as needed. All clinicians will be educated to ensure the medication list is current and in the patient's home via in-service. This education will be provided by the DON by 8/6/25 with a new policy and procedure to reflect the requirements. This will be tracked by ensuring the medication list is current at monthly supervisory visits by DON for goal of 100% compliance within one month. Policy and procedure will be created by 8/6/25.	

	6. During an interview on 06/06/2025 at 3:10 PM, the DON indicated being unaware of the requirement for a written medication list to be provided to patients by the agency. She was unsure if they have a policy related to the requirement.			
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on record review and interview, the agency failed to ensure all patients received a list of all current treatments to be administered by personnel for 1 of 2 skilled home visits conducted (Patient #3). Findings include: During a home visit with Patient #3 on 06/06/2025 at 7:30 AM, the nurse surveyor reviewed the patient's folder from the agency. The folder failed to evidence a written list of all treatments, including G-tube (short for gastrostomy tube that is essentially a soft, flexible tube inserted through the skin of your abdomen directly into your stomach for feedings when	G0618	G-0618 All patients will be provided with a list of all treatments to be provided by clinicians including but not limited to g-tube feedings provided by patient's mother who is an RN for patient #3. Education will be provided to all patients of the importance to keep this list accessible to be verified by clinician at visits by DON. All clinicians will be provided with education of the importance of verifying this list of all treatments remaining in the home with each visit and updated as needed via in-service. The DON will ensure this list is Provided to both patients and clinicians by 8/6/25 with a goal of 100% compliance within one month. Policy and procedure will be created by 8/6/25.	2025-06-24

	feeding for nutrition, to be administered for the patient by RN 2. During an interview on 06/06/2025 at 3:10 PM, the DON indicated being unaware of the requirement for a written list of all current treatments to be provided to patients by the agency. She was unsure if they have a policy related to the requirement.			
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager. Based on record review and interview, the agency failed to supply the patient and caregiver written instructions communicating the name and contact information for the home health agency's clinical manager for 3 of 4 home visits conducted (Patient #1, #3, #6). Findings include: 1. During a home visit with Patient #6 on 06/05/2025 at	G0622	G-0622 Nurse and contact information of clinical manager (DON) to remain in folder at the home. Since site visit patients have informed DON that they do not know me as clinical manager but nurse and have name and contact information saved in their phones. All patients will be provided with education on this information to remain in their folders for easy access in their homes. All clinicians will be provided with education on this information to remain in folders and to verify weekly via in-service. For those who do not have cell phones patients have name and contact information of DON written near their home phone. DON will ensure this is done for every patient for their folders by 8/6/25 with a goal of 100% compliance within one month. Policy and procedure will be created by DON by 8/6/25.	2025-06-24

	3:20 PM, a review of the patient's folder provided by the agency, failed to evidence written instructions informing of the name and contact information for the HHA clinical manager. During an interview on 06/05/2025 at 3:25 PM, Patient #6 indicated being unsure of who the Administrator and Clinical Manager of the agency are. Patient #6 indicated being unaware of their contact information. 2. During a home visit with Patient #3 on 06/06/2025 at 7:30 AM, a review of the patient's folder provided by the agency, failed to evidence written instructions informing of the name and contact information for the HHA clinical manager. 3. During a home visit with Patient #1 on 06/09/2025 at 9:30 AM, a review of the patient's folder provided by the agency, failed to evidence written instructions informing of the name and contact information for the HHA clinical manager. 4. During an interview on			

	06/06/2025 at 3:10 PM, the DON and BOM indicated they were unaware of the requirement for written instructions informing patients/caregivers of the HHA clinical manager name and contact information, be provided to patients by the agency. The DON indicated she was unsure if they have a policy related to the requirement.			
G0644	Program data 484.65(b)(1),(2),(3) Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. Based on record review and interview, the agency failed to show documentation of OASIS	G0644	G-0644 Agency failed to incorporate data from OASIS including quality indicator data, measures derived from OASIS where applicable and other relevant data in the design of the current QAPI program. Agency will incorporate OASIS into improvement program. All clinicians will be educated on the new improvement program to include the following: the clinician must use the data collected to monitor the effectiveness of and safety of services and quality of care, clinicians must identify opportunities of improvement via in-service. The frequency and detail of the data collection must be approved by the HHA' s governing body. The QAPI improvement program will be the responsibility of the Administrator and DON. This will be completed by 8/6/25 with a goal of 100% compliance in one month. Policy and procedure to be updated by DON by 8/6/25.	2025-06-24

	the QAPI program for 1 of 1 agency reviewed. Findings include: Review of the agency's QAPI program on 06/10/202, failed to evidence OASIS data being incorporated into the improvement program. During an interview on 06/10/2025 at 12:00 PM, the DON indicated the agency does not incorporate OASIS data into the QAPI program. She indicated she is new to the DON role and will work to correct the issue now that she is aware of the requirement. 410 IAC 17-12-2(a)			
G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations.	G0658	G-0658 The agency was cited for failing to develop, improve, or complete a performance improvement project. The number and scope of distinct improvement projects conducted annually will reflect the scope, complexity and past performance of HHA's services and operations. The HHA will document the quality improvement projects undertaken, the reasons for conducting these projects and the measurable progress achieved on these projects. Performance improvement projects implemented will be added to HHA's QAPI program binder. The DON will be responsible for ensuring the quality improvement projects are undertaken, the reasons for conducting	2025-06-24

	(2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview the agency failed to develop, improve, or complete a performance improvement project for 1 of 1 agency reviewed. Findings include: Review of a policy dated 05/05/2010 and titled "Quality Assurance Program," indicated but was not limited to: "SNHS will have an ongoing Quality Assurance Program which will be the responsibility of the Administrator and/or Administrator of Nursing &The agency will develop, implement, maintain, and evaluate a quality assessment and performance improvement program &" Review of the agency's QAPI program binder on 06/10/2025, failed to evidence current or past performance improvement projects had been implemented. During an interview on 06/10/2025 at 12:00 PM, the DON indicated the agency not		these projects and the measurable progress achieved. This will be completed by 8/6/25 and will be ongoing with a goal of 100% compliance on this program within one month. This program will be followed by our Business Manager and DON to ensure 100% compliance.	

	currently have any performance improvement projects and was unaware of the requirement due to being new to the role. She indicated she will work to get the requirement into place now that she is aware.			
G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. Based on record review and interview, the agency failed to ensure discharge summaries were sent to patients' primary care provider within the specified timeframe after the patient's discharge for 2 of 2 closed records reviewed (Patient #9, #10).	G1022	G-1022 The agency failed to ensure discharge summaries were sent to primary care provider within the specified time frame after the patient's discharge. Our plan for correction was provided with G0564, see below. All discharges will be provided to the primary care provider or receiving facility with the patient's 485 as well as a summary to specifically address all medical information concerning the patient's current condition of illness and treatment, after discharge goals of care, and treatment choices to guarantee the safe and effective transition of care. All clinicians will be educated on sending all necessary medical information pertaining to the patient's current course of illness and treatment, post discharge goals of care, and treatment preferences to the receiving facility or primary care provider to ensure the safe and effective transition of care via an in-service. This will be completed by 8/6/25 with updated policy and procedure. The Business Manager and DON will track all discharges and audit charts quarterly to ensure 100% compliance within one month.	2025-06-24

	Findings include: 1. Review of a policy titled "Completion of Discharge Summary," indicated but was not limited to: "The agency will complete a discharge summary for each client discharged from the agency. A copy of the discharge summary will be made available to the client's physician. The copy may be mailed or faxed to the physician &The top portion on the DC summary shall be completed if it was not completed at the time of admission &The completion of these forms shall be placed in the clinical record &" 2. The clinical record for Patient #9, benefit period 06/29/2024 - 08/27/224, evidenced a discharge date of 07/25/2024 and a discharge order received by the patient's primary physician on 08/29/2024. 3. The clinical record for Patient #10, benefit period 06/08/2024 - 08/06/2024, evidenced a discharge date of 07/26/2024 and a discharge order received by the patient's primary physician on 08/09/2024. 4. During an interview on			

	06/10/2025 at 10:20 PM, the DON and BOM (Business Office Manager) indicated the agency does not currently send discharge summaries to patient's physician at discharge; the agency reaches out to physician to obtain an order for discharge upon discharge need. They indicated a majority of their patients discharge unexpectedly due to loss of payor source approval. They indicated being unaware of a timeframe required for sending discharge summaries to the primary care provider. 410 IAC 17-15-1(a)(6)			
N0000	Initial Comments This visit was for a State Re-Licensure survey of a Home Health Provider. Survey Dates: 06/04/2025 - 06/06/2025 and 06/09/2025 - 06/10/2025 12-Month Unduplicated Skilled Admissions: 1	N0000		

	This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Abbreviations: RN Registered Nurse			
N0447	Home health agency administration/management 410 IAC 17-12-1(c)(4) Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on record review and interview, the administrator failed to ensure public information was accurate and up to date for 1 of 1 home health agency. Findings include: Review of the agency's information on file with the state shows the hours of	N0447	Our office assistant was in the building. She didn't hear anyone come in door as she works with charts usually in the back of office. (HR) was delivering needed paperwork to one of our HHA's. Our DON was out doing supervisory visits. and business manager was attending a zoom for IHCP. We have poor internet access at office, so this was done at her home. Office hours have been replaced on door. We have a board meeting scheduled on 7/8/25 to discuss hours of operation due to upcoming changes with the Medicaid Program. We hope to keep hours of M-F 9am-3pm but this is subject to change with possible cutbacks. We will update state after our meeting of any changes. A new sign has been ordered to replace our last one which was storm damaged. It is expected to arrive by July 7. We will prevent this from reoccurring by assuring the state is updated with correct hours moving forward. Administrator and Business Manager will be responsible for this moving forward.	2025-07-08

	Tuesday, and Thursday from 9:00 AM to 4:00 PM. A letter dated September 26, 2022, indicated the state received information from the agency to change office hours to 9:00 AM to 4:00 PM, and this occurred during a survey completed on February 4, 2021. On arrival to the agency on 6/4/2025, there were no vehicles parked at the location and the hours listed on the window indicated the office was open on Monday, Tuesday, Thursday, and Friday from 9:00 AM to 3:00 PM and available by appointment on Wednesday. The lights appeared to be off inside the building. Surveyors attempted to call the phone number listed and left a message with the messaging system which was returned by the Aide Scheduler at 2:02 PM and he indicated the door was locked but someone was probably there. He indicated the Business Office Manager said she was there and that she had possibly stepped out for an early lunch when surveyors had been at the agency. He indicated he was out delivering notes to the aides at patient's homes and that's what he does			

	on Wednesdays. He indicated he is the staff member that keeps the phone and is always available and on call. The agency failed to notify the state of the change in office hours to ensure they were accurate. During an interview on 06/05/2025 at 9:19 AM, the administrator indicated the agency is open Monday through Friday from 9:00 AM to 5:00 PM. The Business Office Manager indicated the hours needed to be updated if those are the hours listed because that is not the hours the office is open.			
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:	N0464	N-0464 Agency was cited for failure to evidence a 2-step PPD (agency done 1-step) was implemented upon hire and annually. All new hires moving forward will have 2-step PPD with accurate documentation as baseline. Education and training will be provided to all staff on the required testing at the health department (2-step PPD) and assuring proper documentation to provide in the staff personnel record upon hire and annually. This will be effective immediately with updated policy and procedure to be completed by DON in one month by 8/6/25 with a goal of 100% compliance.	2025-06-24

(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 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 all employees were compliant with Tuberculosis (TB) screening and testing requirements upon hire in accordance with state statute for 2 of 2 RN personnel files reviewed (RN 1, 2).

Findings include:

1. Review of a policy titled "Mantoux Tuberculin Test," indicated but was not limited to: "The agency will accept documentation of Mantoux testing from another source if the PPD SKIN TEST IS UNDER 1 YEAR FROM LAST TEST DATE and the test results are NEGATIVE."

2. The personnel record for RN 1, date of hire 06/03/2024, failed to evidence a baseline tuberculosis status was documented upon hire to the agency. The record evidenced a 1-step PPD (a skin test used to determine TB status), was completed upon hire. No further baseline testing was documented.

3. The personnel record for RN 2, date of hire 08/10/2023, failed to evidence a baseline tuberculosis status was documented upon hire to the agency. The record evidenced a 1-step PPD (a skin test used to determine TB status), document was obtained upon hire. No further baseline testing was documented.

4. During an interview on 06/10/2025 at 11:27 AM, the Medical Records Clerk indicated new

	personnel receive a 1-step Mantoux tuberculin skin test (a skin test to obtain baseline TB status in healthcare workers) upon hire. She indicated the agency has never required a 2-step test for baseline Tuberculosis testing. 5. During an interview on 06/10/2025 at 12:27 PM, the Business Office Manager indicated the agency has never required a 2-step skin test for Tuberculosis testing. She indicated with them being a small business already failing to receive payment from their payor source, it's a concern that the requirement could increase operating costs.			

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
Michele Altepeter	DON	7/7/2025 2:16:57 PM