STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K080	A. BUILDING B. WING	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lifestyles Homecare LLC	107 FEDERAL DRIVE, CHESTERFIELD, IN, 46017

(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: June 3, 4, 5, 6 and 9, 2025 Active Census: 68 At this Emergency Preparedness survey, Lifestyles Homecare LLC was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000	The plan of correction is submitted under Federal and State Regulations and status applicable to health care providers. This plan of correction does not constitute an admission of liability on the part of the agency and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance.	
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider.	G0000	The plan of correction is submitted under Federal and State Regulations and status applicable to health care providers. This plan of correction does not constitute an admission of liability on the part of the agency and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings	

	Survey Dates: June 3, 4, 5, 6 and 9, 2025 12 Month Unduplicated Skilled Admissions: 16 Survey was announced as partially extended on 6/05/25 at 12:09 PM <u>Abbreviations</u> ATTC-Attendant Care, CM-Clinical Manager, HHA-Home Health Aide, HMK-Homemaker, RN-Registered Nurse, POC-Plan of Care, SN-Skilled Nurse, SOC-Start of Care QR 6/16/25 A2		constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance.	
G0436	Receive all services in plan of care 484.50(c)(5) Receive all services outlined in the plan of care. Based on record review and interview, the home health agency failed to ensure the patient received services as ordered on the POC for 1 of 1 active record reviewed with a SOC in the past 60 days (Patient #7).	G0436	Based on the deficiency an educational in-service was conducted on 6-12-25 by the DON to educate the RN Case Mangers, staffing coordinator and ADON that the agency must inform the physician to any changes in the current home care orders and document in the clinical note. If a patient is admitted to home care and has physicians orders to provide services but the agency is waiting for insurance approval for the services the agency must document in the clinical record the reason for the delay in service and also notify the physician and the patient about the reason for the delay in service. When the nurse that is writing the admission orders received by the physician for homecare services, the nurse should request to the physician the need for the order to state services will start when the prior authorization is approved by the insurance company. The nurse should also follow up and notify the physician and the patient when the services are approved by insurance and document in	2025-06-13

	Findings include: 1. The undated agency policy Home Health Care Patient Rights indicated Patients have the right to: the care to be furnished, based on the comprehensive assessment, the frequency of visits, any changes in the care to be furnished and has the right to receive all services outlined in the plan of care. 2. Patient #7 s clinical record evidenced a SOC on 4/8/25 and included a POC for the certification period 4/08/25 to 6/06/25. The POC indicated the patient was to receive HHA visits four to eight hours a day, one to two times a day, two to five days a week for 9 weeks; ATTC visits two to five hours a day, one to two times a day, two to five days a week for 9 weeks; and HMK visits two to four hours, one to two days a week for 9 weeks effective 4/08/25. The clinical record failed to evidence Patient #7 received HHA, ATTC and HMK visits as ordered during the week of 4/08/25 and failed to evidence documentation that Patient #7 and the physician were notified of not receiving		the clinical note that physician and patient were notified when the prior authorization from the insurance gets approved and when home care services will start. Case managers, staffing coordinator and ADON understand the content of the in-service and will follow agency policy under Home Health Care Patient Rights in reference to: patients have the right to: the care to be furnished, based on the comprehensive assessment, the frequency of visits, any changes in the care to be furnished and has the right to receive all services outlined in the plan of care. The DON and ADON completed an audit on all current patients to determine if the the deficiency was found in any other clinical records. The deficiency was not found in any other clinical records except the patient #7 indicated by the surveyor. The DON or ADON will complete random chart audits of 50% of the clinical records of any new admissions quarterly for evidence that the policy is being followed and patients are received care per physicians orders. The results of the clinical audits will be discuses and the QA meeting.	

	POC visit frequencies as ordered. 3. During an interview on 6/09/25 at 12:18 PM, RN 4 confirmed Patient #7 did not receive any HHA visits the week of 4/08/25 and relayed the HHA visits began the following week on 4/14/25 after insurance approval was received. At 12:25 PM, she also confirmed the clinical record did not evidence any documentation of the delay reason and did not include documentation the patient or physician was notified in the delay of services.			
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;	G0574	Based on the deficiency the DON held an educational in-service meeting with the RN Case Managers and ADON on 6-12-25. The in-service education meeting content included discussion on respite care orders requiring a frequency and duration of visits based on the Notice of Action provided by waiver services. Educated RN Case Mangers and ADON on the agency policy "Plan of Care: indicates the plan of care shall be completed in full to include type, frequency and duration of all visits/services. Case managers will conduct a complete audit on all of their current patients with respite care service orders by 6-20-25 to determine if the respite orders include a frequency and duration. The case mangers will also obtain orders from the physician for frequency and duration of respite care visits if the current respite care orders do not include frequency and duration. The DON or ADON will perform chart audits on 50% of patients with respite care orders quarterly to ensure	2025-06-20

	(vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and 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 observation, record review, and interview, the home health agency failed to ensure the POC included the indication for all as needed medications for 1 of 1 patient record reviewed with a home visit observation with HHA services (Patient #4) and failed to ensure the frequency and duration of visits to be made for 3 of 3 patient records reviewed with respite services (Patient #2, 5 and 8). Findings include: 1. The undated agency policy		respite care orders include frequency and duration based on NOA received from waiver services. The results of the chart audits will be reviewed and discussed at the QA meetings. This deficiency also included a deficiency that surveyor found a patient had a PRN medication with no indication for use. Based on the deficiency the DON held an educational in-service with RN Case Managers and ADON on 6-12-25. The in-service content included discussion on medication orders for PRN use. All physician ordered PRN medication must include an indication for use. Agency policy "Medication Policy" indicates the medication profile shall be reviewed by a registered nurse every 60 days and updated whenever there is a change or discontinuation in medication. ADON conducted an audit on 6-13-25 on all PRN medications on all patients and found that no other patients with PRN medication orders were documented without an indication for use except for the one patient with the Tramadol order as indicated on the deficiency. DON or ADON will perform chart audits on 25% of patients each quarter to ensure all prn medications have an order to include indication for use. The results of the chart audits will be reviewed and discussed at the QA meeting.	

	the medication profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation in medication. 2. The undated agency policy Plan of Care indicated the Plan of Care shall be completed in full to include type, frequency and duration of all visits/services. 3. Patient #4 s clinical record evidenced a SOC on 9/26/22 and included a POC for the certification period 5/12/25 to 7/10/25. The POC evidenced the following medication: a) Tramadol 50 milligrams (mg), 1 tab by mouth every 8 hours as needed. The medication profile failed to include an indication for use. During an interview on 6/05/25 at 11:32 AM, RN 3 confirmed the Tramadol did not have an indication listed on the POC for as needed use and relayed it should be listed to take as needed for pain. 4. Patient #2 s clinical record included a POC for the			

	7/18/25 with orders for SN visit frequencies of six to ten hours a day, four to five days a week for 9 weeks and respite SN visit frequencies Per Mother s Request. The POC failed to include the frequency and duration of respite SN visits. During an interview on 6/09/25 at 12:11 PM, RN 4 verified the POC for Patient #2 did not include any frequency orders for respite SN visits. 5. Patient #5 s clinical record included a POC for the certification period 5/19/25 to 7/17/25 with orders for SN visit frequencies of one to three hours a day, four to seven days a week; HHA visit frequencies of one to eight hours a day, one to three times a day, four to seven days a week; ATTC visit frequencies of two to six hours, one to two times a day, four to seven days a week and respite HHA visit frequencies Per Patient/Family Request. The POC failed to include the frequency and duration of respite HHA visits. During an interview on 6/09/25 at 11:10 AM, RN 4 verified the POC for Patient #5 did not			

	include any frequency orders for respite HHA visits. 6. Patient #8 s clinical record included a POC for the certification period 1/19/25 to 3/19/25 with orders for respite SN visit frequencies Per Mother s Request. The POC failed to include the frequency and duration of respite SN visits. During an interview on 6/09/25 at 11:18 AM, RN 4 verified the POC for Patient #8 did not include any frequency orders for respite SN visits and she relayed the frequency orders should have been listed on the POC and approved by the physician. 410 IAC 17-13-1(a)(1)(C)(iii)(ix)			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the home health agency failed to ensure services were provided only as ordered by a physician or allowed	G0580	Based on the deficiency the DON held an educational in-service with RN Case Managers and ADON on 6-12-25. The in-service contained education on obtaining a physicians verbal order to continue home care service until the plan of care/485 was signed by the physician. This verbal order received by patients physician would stand in place as the acting orders until the plan of care/485 was signed by physician and returned back to agency and placed into the patients clinical record. Case Managers and ADON understood the content. Educated Case Managers and ADON on the agency policy "Plan of Care" that indicates home care services are furnished under the supervision and direction of the patients physicians. On 6-13-25 the RN Case Mangers completed a clinical record audit on	2025-06-16

	practitioner for 7 of 7 active patient records reviewed (Patient #1, 2, 3, 4, 5, 6 and 7). Findings include: 1. The undated agency policy Plan of Care indicated home care services are furnished under the supervision and direction of the client s physician. 2. Patient #1 s clinical record included a POC for certification period 5/28/25 to 7/26/25 with orders for SN visit frequencies of four to eight hours a day, five to seven days a week. The record evidenced SN visits were performed on 5/28/25, 5/29/25, 5/30/25, 6/02/25, 6/03/25 and 6/04/25. The clinical record for Patient #1 failed to include a verbal or signed written order for the SN frequencies was obtained prior to the above visits performed. During an interview on 6/05/25 at 11:38 AM, RN 3 relayed Patient #1 did not have any changes and confirmed she did not collaborate with the physician. The recertification POC was created and faxed to the physician for signature.		all of their patients to determine if the recertification oasis assessments contained physician signed verbal orders to be in place until the plan of care/485 was signed by physician and placed into the patients clinical record. Effective 6-16-25 the RN completing the oasis recertification assessment on the patient will contact the physician after completing the oasis assessment to obtain and write the verbal physician orders to continue to provide home care services that include frequency and duration of care to stand in place as the acting orders until the plan of care/485 was signed by physician and returned back to agency and placed into the patients clinical record. DON or ADON will perform chart audits on 25% of patients each quarter to ensure verbal orders are obtained at the time of the recertification oasis assessment to continue homecare services until the plan of care/485 signed by physician. The results of the chart audits will be reviewed and discussed at the QA meetings.	

	3. Patient #2 s clinical record included a POC for the certification period 5/20/25 to 7/18/25 with orders for SN visit frequencies of six to ten hours a day, four to five days a week for 9 weeks and respite SN visit frequencies Per Mother s Request. The record evidenced SN visits were performed on 5/20/25, 5/21/25, 5/22/25, 5/23/25, 5/26/25, 5/27/25 and 5/28/25. The clinical record for Patient #2 failed to include a verbal or signed written order for the SN frequencies was obtained prior to the above visits performed. During an interview on 6/05/25 at 11:40 AM, RN 3 relayed Patient #2 did not have any changes and confirmed she did not collaborate with the physician. The recertification POC was created and faxed to the physician for signature. 4. Patient #3 s clinical record included a POC for the certification period 5/30/25 to 7/28/25 with orders for SN visit frequencies of two to eight hours a day, one to two times a day, five to seven days a week. The record evidenced SN visits were performed on 5/30/25,			

	6/02/25, 6/03/25, 6/04/25, 6/05/25 and 6/06/25. The clinical record for Patient #3 failed to include a verbal or signed written order for the SN frequencies was obtained prior to the above visits performed. During an interview on 6/05/25 at 11:43 AM, RN 3 relayed Patient #3 she did not collaborate with the physician and the recertification POC was created and faxed to the physician for signature. 5. Patient #4 s clinical record included a POC for the certification period 5/12/25 to 7/10/25 with orders for SN visit frequencies of zero to one hour a day, zero to one day a week for 9 weeks; HHA frequencies of three to nine hours a day, one to two times a day, three to seven days a week; ATTC visit frequencies of one to five hours a day, one to two times a day, four to seven days a week; and HMK visit frequencies of two to four hours, zero to two days a week for 9 weeks. The record evidenced SN visits were performed on 5/12/25 and 5/19/25; HHA visits were performed on 5/12/25, 5/13/25, 5/14/25, 5/15/25, 5/16/25,			

	5/19/25, 5/20/25, 5/21/25 and 5/22/25; ATTC visits were performed on 5/13/25, 5/17/25, 5/20/25 and 5/21/25 and a HMK visit was performed on 5/14/25. The Clinical record for Patient #4 failed to include a verbal or signed written order for the SN frequencies was obtained prior to the above visits performed. During an interview on 6/05/25 at 11:45 AM, RN 3 relayed Patient #4 did not have any changes and confirmed she did not collaborate with the physician. The recertification POC was created and faxed to the physician for signature. 6. Patient #5 s clinical record included a POC for the certification period 5/19/25 to 7/17/25 with orders for SN visit frequencies of one to three hours a day, four to seven days a week; HHA visit frequencies of one to eight hours a day, one to three times a day, four to seven days a week; ATTC visit frequencies of two to six hours, one to two times a day, four to seven days a week and respite HHA visit frequencies Per Patient/Family Request. The			

	performed on 5/19/25, 5/20/25, 5/21/25, 5/22/25, 5/23/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 6/02/25, 6/03/25, 6/04/25, 6/06/25 and 6/07/25; HHA visits were performed on 5/19/25, 5/20/25, 5/21/25, 5/22/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 5/31/25, 6/01/25, 6/02/25, 6/03/25, 6/04/25, 6/06/25, 6/07/25 and 6/08/25; and ATTC visits were performed on 5/19/25, 5/20/25, 5/21/25, 5/22/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 5/31/25, 6/01/25, 6/02/25, 6/03/25, 6/04/25, 6/06/25, 6/07/25 and 6/08/25. The Clinical record for Patient #5 failed to include a verbal or signed written order for the SN, HHA and ATTC frequencies was obtained prior to the above visits performed. During an interview on 6/05/25 at 11:53 AM, RN 4 relayed Patient #5 did not have any changes. She created the recertification POC and faxed it to the physician for signature. 7. Patient #6 s clinical record included a POC for the			

	certification period 5/29/25 to 7/27/25 with orders for SN visit frequencies of four to eight hours a day, six to seven days a week. The record evidenced SN visits were performed on 5/29/25, 5/30/25, 5/21/25, 6/01/25, 6/02/25, 6/03/25, 6/04/25, 6/05/25, 6/06/25, 6/07/25 and 6/08/25. The Clinical record for Patient #6 failed to include a verbal or signed written order for the SN frequencies was obtained prior to the above visits performed. During an interview on 6/05/25 at 11:58 AM, RN 4 relayed she did not collaborate with the physician for the recertification POC. She created the recertification POC and faxed it to the physician for signature. 8. Patient #7 s clinical record evidenced a SOC on 4/08/25 and included a POC for the certification period 4/08/25 to 6/06/25 with orders for HHA visit frequencies of four to eight hours a day, one to two times a day, two to five days a week for 9 weeks. The record evidenced HHA visits were performed on 4/14/25 and 4/15/25. The Clinical record for Patient #7 failed to include a verbal or			

	signed written order for the HHA frequencies was obtained prior to the above visits performed. During an interview on 6/05/25 at 12:04 PM, RN 4 relayed she did not collaborate with the physician for the POC frequency orders. She created the POC and faxed it to the physician for signature. 9. During an interview on 6/05/25 at 11:49 AM, the Administrator verified the home health agency did not collaborate with the physicians for POC frequency orders. The POC s were created by the Alternate Administrator and sent to the physicians for review. 410 IAC 17-13-1(a)			
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date.	G0588	Based on the deficiency the DON held an educational in-service for RN Case Managers and ADON on 6-12-25. Re-educated and reviewed the agency policy that reads "Plan of Care" indicated home care services are furnished under the supervision and direction of the patients physician and the total Plan Of Care shall be reviewed by the attending physician and agency personnel as often as the severity of the patients condition requires, but at least one time every sixty (60) days. Effective 6-12-25 the DON instructed RN Case Managers and ADON to complete the 60 day summary on their patient according to the scheduled due date and fax out 60 day	2025-06-17

	Based on record review and interview, the home health agency failed to ensure the POC was reviewed with the physician or attending practitioner no less frequently than once every 60 days for 4 of 6 active records reviewed with a recertification (Patient #2, 4, 5, and 6). Findings include: 1. The undated agency policy Plan of Care indicated home care services are furnished under the supervision and direction of the client s physician and the total Plan of Care shall be reviewed by the attending physician and agency personnel as often as the severity of the client s condition requires, but at least one time every sixty (60) days. 2. Patient #2 s clinical record evidenced a SOC on 6/15/20. The record included a POC for the certification period 5/20/25 to 7/18/25 and documents titled 60 Day Summary sent 3/27/25 and 5/28/25. The recertification POC was sent to the physician on 5/28/25, 62 days after the last update was sent to the physician. The		summary to the physician immediately following completion of the 60 day summary, attach the fax confirmation to the 60 day summary for proof it was sent to the physician. The 60 day summary with the attached fax confirmation will be placed into the patients clinical record. RN Case Managers and ADON understood all instructions and will begin the new process immediately. The DON and ADON completed an audit on 6-17-25 on all patients clinical records to determine if this deficiency applied to any other patients. Audit indicates that the 60 day summary was being faxed to the physician at the same time that the completed plan of care/485 was being sent therefor not being sent on the actual day the 60 day summary was due on, causing the 60 day summary to be approximately 2-3 days late on patients. The DON or ADON will perform chart audits on 25% of clients each quarter to ensure the 60 day summaries are being sent to the physicians on time and according to the policy and that the new instructions given to RN Case Managers and ADON are being followed. The results of the chart audits will be reviewed and discussed at the QA meetings.	

	record failed to include collaboration with the physician for the recertification POC and failed to evidence the recertification POC and 60 Day Summary were sent to the attending physician at least every 60 days. During an interview on 6/05/25 at 11:40 AM, RN 3 relayed Patient #2 did not have any changes and confirmed she did not collaborate with the physician. During an interview on 6/09/25 at 12:11 PM, the Alternate Administrator/RN 4 confirmed the POC and 60 Day Summary were not sent to the physician until 5/28/25. 3. Patient #4 s clinical record evidenced a SOC on 9/25/22. The record included a POC for the certification period 5/12/25 to 7/10/25 and documents titled 60 Day Summary sent 3/17/25 and 5/22/25. The recertification POC was sent to the physician on 5/22/25, 66 days after the last update was sent to the physician. The record failed to include collaboration with the physician			

	failed to evidence the recertification POC and 60 Day Summary were sent to the attending physician at least every 60 days. During an interview on 6/05/25 at 11:45 AM, RN 3 relayed Patient #4 did not have any changes and confirmed she did not collaborate with the physician. During an interview on 6/09/25 at 12:04 PM, the Alternate Administrator/RN 4 confirmed the POC and 60 Day Summary were not sent to the physician until 5/22/25. 4. Patient #5 s clinical record evidenced a SOC on 2/01/13. The record included a POC for the certification period 5/19/25 to 7/17/25 and documents titled 60 Day Summary sent 3/20/25 and 6/04/25. The recertification POC was sent to the physician on 6/04/25, 76 days after the last update was sent to the physician. The record failed to include collaboration with the physician for the recertification POC and failed to evidence the recertification POC and 60 Day Summary were sent to the			

attending physician at least every 60 days.

During an interview on 6/05/25 at 11:53 AM, RN 4 relayed Patient #5 did not have any changes. She created the recertification POC and faxed it to the physician for signature.

During an interview on 6/09/25 at 11:57 AM, the Alternate Administrator/RN 4 confirmed the POC and 60 Day Summary were not sent to the physician until 6/04/25.

5. Patient #6 s clinical record evidenced a SOC on 2/19/21. The record included a POC for the certification period 5/29/25 to 7/27/25 and documents titled 60 Day Summary sent 4/02/25 and 6/05/25. The recertification POC was sent to the physician on 6/05/25, 64 days after the last update was sent to the physician. The record failed to include collaboration with the physician for the recertification POC and failed to evidence the recertification POC and 60 Day Summary were sent to the attending physician at least every 60 days.

During an interview on 6/05/25

	at 11:58 AM, RN 4 relayed she did not collaborate with the physician for the recertification POC. She created the recertification POC and faxed it to the physician for signature. During an interview on 6/09/25 at 12:08 PM, the Alternate Administrator/RN 4 confirmed the POC and 60 Day Summary were not sent to the physician until 6/05/25. 6. During an interview on 6/05/25 at 11:49 AM, the Administrator verified the home health agency did not collaborate with physicians for POC frequency orders. The POC s were created by the Alternate Administrator and sent to the physician for review. 7. During an interview on 6/09/25 at 11:55 AM, the Alternate Administrator/RN 4 relayed the physician should be updated every 60 days. 410 IAC 17-13-1(a)(2)			
G0682	Infection Prevention 484.70(a)	G0682	Based on the deficiency an educational in-service for all RNs and LPNs is scheduled for 6-30-25 at 7am, 2pm, or 6pm in the skills lab at Lifestyles Homecare. The DON will conduct the in-service on G-Button Care and G-Button Feeding procedures, complete a written exam to document competency and assure	2025-07-03

	Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to ensure employees followed standards of practice for hand hygiene to reduce the spread of infections for 1 of 2 home visit observations with an RN (Patient #2). Findings include: 1. Review of Lippincott s best practice guidelines indicated one should perform hand hygiene and put on clean gloves before removing the plug or cap of the gastrostomy tube. 2. During a home visit observation conducted with Patient #2 and RN 1 on 6/04/25 beginning at 11:50 AM, RN 1 connected the extension tubing to Patient #2 s gastrostomy tube (G tube) and checked for residual (the amount of fluid aspirated from the stomach before a feeding). RN 1 then donned gloves and connected the feed tubing to Patient #2 s extension tubing. RN 1 failed to		compliance and knowledge of the G-Button Care and G-Button Feeding Policy and Procedure and will conduct a skills check off for competency on the mannequin in the skills lab for G-Button Care and G-Button Feedings. All RNs and LPNs must pass with complete accuracy and satisfactory of skills and written exam. The in-service will also re-educate all RNs and LPNs on infection control measures and the purpose of the policy to prevent transmission of infections and communicable diseases. To comply with the guidelines of the CDC in creating a safe environment for all health care workers and patients. Review the infection control policy with all RNs and LPNs that prior to performing G-Button care, Nurses must perform handwashing and apply gloves before the G-tube feeding procedure. All RNs and LPNs will follow policies in place. DON will complete a one-time home visit during the week of June 30, 2025 to patients that have G-Buttons that have skilled nursing performing the care of the G-Button and the G-Button feedings to observe nurse perform skills correctly in regard to G-Button and to ensure that infection control measures are being met during the G-Button Care and G-Button Feeding procedure. DON will complete random home visits on 50% of patients with G-Buttons that have skilled nursing to perform G-Button Care and G-Button Feedings each quarter for evidence that all G-Button procedures are being followed per policy and proper infection control measures are being met per policy. The results of the random observation audit will be reviewed and discussed at the QA meetings.	

	wear gloves while connecting the extension tubing and failed to perform hand hygiene prior to putting on gloves. 3. During an interview on 6/04/25 at 2:04 PM, Surveyor asked if gloves should be worn when accessing the G-tube site, the Administrator stated not technically since the gut is dirty. Surveyor then asked if the nurse should have performed hand hygiene before putting on gloves and the Administrator relayed it is all the same dirty gut area so I don t think so. 410 IAC 17-12-1(m)			
N0000	Initial Comments This visit was for a State Re-Licensure survey of a Home Health Provider. Survey Dates: June 3, 4, 5, 6 and 9, 2025 12 Month Unduplicated Skilled	N0000	The plan of correction is submitted under Federal and State Regulations and status applicable to health care providers. This plan of correction does not constitute an admission of liability on the part of the agency and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance.	

	Admissions: 16			

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
Amy Pope	RN, DON	6/24/2025 12:52:06 PM