

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K065	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/07/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HELP AT HOME SKILLED CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 PROFESSIONAL BLVD SUITE B , EVANSVILLE, Indiana, 47714
--	---

(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
--------------------	--	---------------	---	----------------------

G0000	<p>INITIAL COMMENTS</p> <p>This visit was for a Federal Recertification and State Re-Licensure survey of a Provider.</p> <p>Survey Dates: September 27 - October 7, 2022</p> <p>Census: 176</p> <p>This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.</p> <p>QR Completed 10/19/2022 A4</p>	G0000		
G0710	<p>Provide services in the plan of care</p> <p>CFR(s): 484.75(b)(3)</p> <p>Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care;</p> <p>This ELEMENT is NOT MET as evidenced by:</p> <p>Based on record review and interview, the agency failed to ensure duration and frequency of services ordered by the physician were completed for 2 of 7 active patient records reviewed. (Patients 4 and 5)</p> <p>Findings include:</p> <p>1. A revised January 4, 2022 policy titled Plan of Care was provided by the Administrator (AS1) on 9/28/2022 at 1:36 p.m. The policy indicated but was not limited to, "Policy: The plan of care/treatment shall be developed in consultation with the agency staff to ensure that care provided is appropriately [sic] and planned to meet each client's specific assessment needs..."</p> <p>2. The complete clinical record for patient 4, start of care date 3/22/22, was reviewed on 10/3/2022, and included a plan of care for the certification period 7/20/2022 to 9/17/2022 with orders for skilled nursing services 10 hours/day</p>	G0710		

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K065	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/07/2022
NAME OF PROVIDER OR SUPPLIER HELP AT HOME SKILLED CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 PROFESSIONAL BLVD SUITE B , EVANSVILLE, Indiana, 47714	
(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
G0710	<p>Continued from page 1 for 5 days/week, not to exceed 50 hours/week. For weeks 7/20/22-7/23/22, 7/24/22-7/30/22, 7/31/22-8/6/22, 9/4/22-9/10/22 and 9/11/22-9/17/22 there were 0 of 50 skilled nursing hours provided. The week of 8/7/22-8/13/22 8 of 50 hours of skilled nursing were provided and weeks 8/14/22-8/20/22 and 8/28/22-9/3/22 24 of 50 hours of skilled nursing were provided. The agency failed to provide the ordered number of hours for number of days each week of the certification period.</p> <p>3. The complete clinical record for patient 5, start of care date 4/20/22, was reviewed on 10/3/2022, and included a plan of care for the certification period 8/18/2022 to 10/16/2022 with orders for home health aide services 1 hour/day for 5 days/week. For week 8/18/22-8/20/22 1.5 of 2 hours were completed. Completed hours for week 8/28/22-9/3/22 was 4.25 of 5, week 9/4/22-9/10/22 was 4.75 of 5, week of 9/11/22-9/17/22 was 3.50 of 5, and week 9/18/22-9/24/22 was 3.50 of 5. The agency failed to provide the ordered number of hours for number of days each week of the certification period.</p> <p>4. During an interview with Branch Manager (AS3) and Alternate Administrator (AS2) on 10/5/2022 at 1:51 p.m., it was indicated that patient 4 did not receive all hours ordered due to staff shortage and that patient 4's grandmother helped out with hours. The documentation for the missed hours was not uploaded to the patient record. AS3 and AS2 indicated other agencies had been contacted to find out if they could staff this patient as well without any luck. Both administrative staff stated the hours should be completed as ordered</p> <p>410 IAC 17-14-1(a)(1)(H)-RN 410 IAC 17-14-1(a)(2)(F)-LPN</p>	G0710		