STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K118	A. BUILDING B. WING	04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMETOWN HOME HEALTHCARE INC	302 E NORTH B STREET, GAS CITY, IN, 46933

(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	INITIAL COMMENTS This visit was for a third Post Condition Revisit of a Federal Recertification and State Re-licensure survey of a Provider. Survey Dates: April 10 and 11, 2023 12 Month Unduplicated Skilled Census: 4 During this post condition revisit survey, four (4) condition-level deficiencies and 10 (ten) standard-level deficiencies were found corrected; three (3) standard-level deficiencies were re-cited and two (2) new standard level deficiencies were cited.	G0000	HOMETOWN HOME HEALTHCARE INC is submitting the following Plan of Correction in response to the 2567 issued by ISDH and/or CMS as it is required to do by applicable state and federal regulations. The submission of this Plan of Correction is not intended as an admission, does not constitute an admission by and should not be construed as an admission by HOMETOWN HOME HEALTHCARE INC that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to patients of the Agency. HOMETOWN HOME HEALTHCARE INC desires this Plan of Correction to be considered our Allegation of Compliance."	

	This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Based on the Condition-level deficiencies during the October 21, 2022, survey, the home health agency was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on October 18, 2022. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, the agency is precluded from operating or being the site of a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning October 21, 2022, and continuing through October 20, 2024. QR: Area 2 4/20/23			
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	G0574	Director of Nursing will in-service all nurses on the required elements for a plan of care: (05/04/23) 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	2023-05-04

	equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and 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 home health agency failed to ensure the plan of care [POC] included indications for use for all active as needed medications for 2 of 5 active patient records reviewed (Patient #2 and 12). Findings include: Review of Policy #2.06 titled "Care Planning/ 485" indicated the elements which must have been incorporated into the		made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and 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. Director of Nursing will audit all current patient plans of care to ensure they contain the required elements including reason(s) for when patient may take an "as needed" medication. Director of Nursing/nurse will contact MD to obtain verbal order for any plan of care missing a required element. (Date completed) Director of Nursing/designee will audit all plans of care submitted weekly to ensure they contain all required elements. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

	included but not limited to all medications and treatments. Review of Patient #2's clinical record included a POC for the recertification period dated 03/28/23 – 05/26/23, that included the as needed medications: 1) albuterol 2.5 milligrams / 3 milliliters inhalation solution every 4 - 6 hours as needed inhaled, 2) albuterol sulfate 90 micrograms 2 puffs every 4 hours as needed inhaled, and 3) Tylenol 500 milligrams oral tablet 1 tablet every 6 hours as needed by mouth. The POC failed to evidence the indications for use for each of the as needed medications. Review of Patient #12's clinical record included a POC for the recertification period 02/21/23 – 04/21/23. The POC included the medication ondansetron 4 milligrams oral tablet disintegrating twice a day, as needed, by mouth. The POC failed to provide the indications for use for the as needed medication. During an interview on 04/11/23 at 4:15 PM, the			

	needed medications on the POC medication list should include the indications for use. 410 IAC 17-13-1(a)(1)(D)(ix)			
G0578	Conformance with physician orders 484.60(b) Standard: Conformance with physician or allowed practitioner orders. Based on record review and interview, the home health agency failed to follow their own policy and failed to ensure the Plan of Care was followed for 2 of 2 active clinical records reviewed receiving skilled nursing services (Patient #1 and 9). Findings include: 1. Review of Policy #2.06 "Care Planning/ 485" indicated all staff should follow the doctor ordered POC and indicated all services were to be performed only as ordered by the physician. 2. Review of Patient #1's clinical record evidenced a POC (plan of care) for certification period 02/11/2023 – 04/11/2023 included orders for SN (skilled	G0578	Director of Nursing will in-service all nurses/aides on need to follow the patient's plan of care. (04/28/23) Director of Nursing will instruct person(s) doing visit scheduling that patient is to be scheduled according to frequency/duration listed on plan of care. If unable to schedule patient according to MD orders Director is to be notified. (04/28/23) Director of Nursing/designee will audit all visit schedules weekly on Monday to ensure visit schedule reflects frequency/duration ordered on plan of care. (On-going) Director of Nursing/designee will audit all visit notes submitted weekly to ensure visit frequency and duration is met. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-04-28

	per day, 3 - 5 days per week and indicated to flush feed tube with 60 ml (milliliters) of water before and after each feed. During a home visit observation on 04/10/23 beginning at 2:01 PM, observed LPN #1 flushed the feed tube with 30 ml of water prior to the feed. When asked about the flush, LPN #1 confirmed they flushed the feed tube with 30 ml of water before the feed. The agency failed to ensure the POC was followed as ordered by the physician. 3. Review of Patient #9's clinical record evidenced a POC for certification period 04/01/2023 – 05/30/2023 which included orders for SN services for 10 - 12 hours per day, 1 - 3 days per week. The clinical record evidenced skilled nursing visits were conducted on 03/06/2023, 03/13/2023, 04/03/2023, and 04/10/2023, each with a duration of 8.0 hours. During an interview on 04/11/2023 at 01:04 PM, the Clinical Manager indicated they were not aware the patient had been receiving SN visits for a shorter time than ordered. The agency secretary indicated the patient had a			

	who was available for fewer hours, and scheduled a nurse for less than the ordered number of hours. The agency failed to ensure the POC was followed as ordered by the physician.			
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 physician orders were obtained, following the recertification assessment, to continue agency services, prior to a new recertification period for 1 of 2 patient records reviewed with recertification since the agency's correction date of 3/11/23 (Patient #2). Findings include: 1. Review of Policy #2.06 "Care Planning/ 485" indicated but not limited to services were to be performed only as ordered by the physician. 2. Review of Patient #2's clinical record evidenced an unsigned	G0580	Director of Nursing will in-service nurses on contacting MD after doing recertification assessment to obtain verbal order to continue ordered services prior to start of new certification period. This will be documented. (04/17/23) Director of Nursing will audit all current patient charts to ensure there is an order to continue services prior to the start of new certification period. If there isn't one nurse will obtain one. (05/04/23) Director of Nursing/designee will audit all recertifications submitted weekly to ensure there is documentation an order was received to continue ordered services prior to the start of the new certification period prior to the start of the new certification period. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-05-04

recertification period 03/28/23 - 05/26/23 which included orders for HHA (Home Health Aide) services for 1 - 2 hours per day, 1 - 3 days per week.

The clinical record failed to evidence documentation of a verbal or written physician order to continue care after the end of the certification period ending 3/27/23.

The clinical record evidenced HHA #2 provided aide services that included, but not limited to, shower, skin care, and assist with ambulation on 03/29/2023, 03/31/2023, 04/03/2023. The agency failed to ensure there was a physician's order to provide services on these dates.

3. During an interview on 04/11/2023 at 01:04 PM, the Clinical Manager indicated a verbal order was received, it would indicate the order was read back and verified and if there was no check in a box to indicate the order was read back, then that meant the physician order was not received verbally and was only faxed to the physician for review and their signature.

4. During an interview on

	04/11/2023 at 4:15 PM, the Clinical Manager confirmed there was no verbal or written order for services to be provided after 3/27/23 for Patient #2. 410 IAC 17-13-1(a)			
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the home health agency failed to follow their own policy and failed to ensure accuracy of patient records for 1 of 5 active patient records reviewed (Patient #2.) Findings include:	G1024	Director of Nursing will in-services clinicians on requirement to date documents with date they were actually created. Director of Nursing will in-service nurses on contacting MD after doing recertification assessment to obtain verbal order to continue ordered services prior to start of new certification period. This will be documented. (04/17/23) Director of Nursing will audit all current patient charts to ensure there is an order to continue services prior to the start of new certification period. If there isn't one nurse will obtain one. (04/17/23) Director of Nursing/designee will audit all recertifications submitted weekly to ensure there is documentation an order was received to continue ordered services prior to the start of the new certification period prior to the start of the new certification period. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-04-17

	Review of Policy #2.21 "Clinical Records" indicated information contained in the clinical record should have been accurate and should have adhered to clinical records documentation standards of practice. Review of Patient #2's clinical record included a POC (plan of care) for the recertification period 02/21/2023 – 04/21/2023. The POC was signed by the Clinical Manager and was dated as signed on 02/17/2023 at 12:00 AM. During the second post condition revisit survey with an exit date of 02/21/2023, the clinical record failed to indicate there was a POC for Patient #2 for the recertification period 02/21/2023 – 04/21/2023. The Clinical Manager failed to date their signature on the POC with the date it was actually created and signed by the Clinical Manager. During the second post condition revisit survey with an exit date of 02/21/2023, the Clinical Manager confirmed the POC for that recertification period had not yet been completed.			

	During an interview with he clinical manager on 4/10/23 at 3 PM, the clinical manager relayed she did not recall the previous review of clinical record 2 and when asked, indicated the agency had no documentary evidence that the attending physician was consulted for the orders on the recertification plan of care beginning on 2/21/23.			
G1028	Protection of records 484.110(d) Standard: Protection of records. The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164. Based on observation and interview, the home health agency failed to ensure all clinical records were safeguarded against loss or unauthorized use for 1 of 1 agency observed. Findings include: 1. Review of Policy #1.12 "Records Retention" indicated medical records must be stored	G1028	Administrator will in-service staff on requirement that patient records are to be kept secure and be behind two locks. Only staff with a need to access a patient's records will have access. (04/24/23) Administrator/designee will ensure patient records are stored appropriately. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-04-24

environment to protect their confidentiality and indicated all doors to file areas should have some form of lock to ensure record safety.

2. On 04/10/2023 at 09:10 AM, observed boxes containing patient records on the floor of the unlocked, unoccupied office that surveyors were directed to work in.

3. During an interview on 04/10/2023 at 10:57 AM, the Administrator indicated they had to go buy a lock to secure the patient records because they had lost the lock they had purchased previously for that purpose.

4. On 04/10/2023 at 3:00 PM, observed the boxes containing patient records were no longer on the office floor. The Administrator indicated they had been moved to the basement storage area.

410 IAC 17-15-1(c)

Deborah Abshire	RN, DON	5/4/2023 9:10:18 AM