STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOME HEALTH CARE INC	3800 W 80TH LN, MERRILLVILLE, IN, 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This visit was for a State complaint survey and a State relicensing survey of a deemed Home Health Agency. Complaint #70910: Unsubstantiated, with unrelated findings. Survey Dates: 07/13/22, 7/14/22, 7/15/22, 7/20/22, 7/21/22, 7/22/22 Facility: #012444 CCN/ Provider: #157633 Census: 74 QR completed by Areas 2 and 3 on 8-12-2022	N0000		2022-09-16

G0000	INITIAL COMMENTS This visit was for a Federal and State complaint survey and a State relicensing survey of a deemed Home Health Agency. Complaint #70910: Unsubstantiated, with unrelated findings. Survey Dates: 07/13/22, 7/14/22, 7/15/22, 7/20/22, 7/21/22, 7/22/22 Facility: #012444 CCN/ Provider: #157633 Census: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. See the State Form for State only deficiencies. QR by Areas 2 and 3 completed 8-12-2022	G0000		2022-09-16
N0524	Patient Care 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff.	N0524	N0524: "Goals were not patient-specific and individualized." Clinical Manager or her designeewill review all care plans to assure that specific goal dates are included ineach	2022-08-22

	(B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview, the agency failed to ensure goals were patient-specific and individualized for 1 (Patient #1) of 7 active records reviewed. Findings include: 1. A review of the plan of care for Patient #1, for the certification period of 3/31/22 5/29/22, evidenced the following goals: Caregiver will be able to verbalize signs and symptoms of		patient-specific and individualized.Clinical Manager or her designee will audit 10 percent of all charts eachquarter to assure that goals are patient-specific and individualized to assurethat compliance is continued to be met. Individualized education will beprovided to clinicians who need it by the Clinical Manager. Clinical Managerwill educate all clinicians by 8-20-2022 on this deficiency and educate on theneed to make goals patient-specific and individualized. Deficiency will becorrected by 8-22-2022.	

(recertification); Caregiver will demonstrate compliance with prescribed wound treatment regimen by end of recert; Caregiver will achieve optimal wound healing & by end of recert; Caregiver will demonstrate proper infection precautions & by end of recert; Caregiver will be able to verbalize signs of skin infection & by end of recert; Patient will remain free of skin infection & during this episode of care; Patient will attain optimal effectiveness of pain management & by end of recert; Caregiver will demonstrate the ability to effectively manage medication by end of recert; Patient s foley catheter will remain patent.

The plan of care failed to indicate how the caregiver would ensure the prevention of skin infections; failed to evidence the meaning of cardiac complications and how cardiac complications would be identified and measured; failed to specify the meaning of compliance with prescribed wound treatment; failed to define "optimal" in terms of a goal for wound healing and how the caregiver would achieve/know they had achieved optimal wound healing; failed to indicate a specific goal to define when "optimal pain management" had been achieved; failed to indicate the necessary measures to ensure the catheter would remain patent; and failed to include any patient-specific and measurable goals related to wound healing and minimizing further integumentary breakdown.

A review of the plan of care for 5/30/22 7/28/22 indicated the same goals identified in the previous plan of care dated 3/31/22 5/29/22. The administrator indicated Patient #1 had made progress toward goals and that this plan of care failed to evidence patient-specific, measurable, goals.

2. On 7/21/22 at 3:15 PM, the administrator indicated the goals were chosen from a drop-down menu in the electronic medical record, or they could be free-typed to include goals that were individualized and patient-specific. The administrator indicated agreement that the goals were not measurable and patient-specific and had not been

	updated based on the patient s progress. The administrator indicated goals were being addressed but the clinicians were not documenting the information in the clinical record.			
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; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;	G0574	G0574: “Goals were not patient-specific and individualized.” Clinical Manager or her designeewill review all care plans to assure that specific goal dates are included ineach plan of care and that goals are patient-specific and individualized.Clinical Manager or her designee will audit 10 percent of all charts eachquarter to assure that goals are patient-specific and individualized to assurethat compliance is continued to be met. Individualized education will beprovided to clinicians who need it by the Clinical Manager. Clinical Manager will educate all cliniciansby 8-20-2022 on this deficiency and educate on the need to make goalspatient-specific and individualized. Deficiency will be corrected by 8-22-2022.	2022-08-22

(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 goals were patient-specific and individualized for 1 (Patient #1) of 7 active records reviewed.

Findings include:

1. A review of the plan of care for Patient #1, for the certification period of 3/31/22 5/29/22, evidenced the following goals: Caregiver will be able to verbalize signs and symptoms of cardiac complications & by end of recert (recertification); Caregiver will demonstrate compliance with prescribed wound treatment regimen by end of recert; Caregiver will achieve optimal wound healing & by end of recert; Caregiver will demonstrate proper infection precautions & by end of recert; Caregiver will be able to verbalize signs of skin infection & by end of recert; Patient will remain free of skin infection & during this episode of care; Patient will attain optimal effectiveness of pain management & by end of recert; Caregiver will demonstrate the ability to effectively manage medication by end of recert; Patient s foley catheter will remain patent.

The plan of care failed to indicate how the caregiver would ensure the prevention of skin infections; failed to evidence the meaning of cardiac complications and how cardiac complications would be identified and measured; failed to specify the meaning of compliance with prescribed wound treatment; failed to define "optimal" in terms of a goal for wound healing and how the caregiver would achieve/know they had achieved optimal wound healing; failed to indicate a specific goal to define when "optimal pain management" had been achieved; failed to indicate the necessary measures to ensure the catheter would remain patent; and failed to include any patient-specific and measurable goals related to wound healing and

	minimizing further integumentary breakdown. A review of the plan of care for 5/30/22 7/28/22 indicated the same goals identified in the previous plan of care dated 3/31/22 5/29/22. The administrator indicated Patient #1 had made progress towards goals and that this plan of care failed to evidence patient-specific and measurable goals. 2. On 7/21/22 at 3:15 PM, the administrator indicated the goals were chosen from a drop-down menu in the electronic medical record, or they could be free-typed to include goals that were individualized and patient-specific. The administrator indicated agreement that the goals were not all measurable and patient-specific and had not been updated based on the patient s progress. The administrator indicated goals were being addressed but the clinicians were not documenting the information in the clinical record.			

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