| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 157608 | A. BUILDING<br>B. WING | 01/25/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOOSIER HOMECARE SERVICES LLC | 614 EAST 53RD STREET, ANDERSON, IN, 46013 |

| (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<br><br>This was a first Post Condition Revisit for a State Complaint Investigation survey completed on 11/29/2022.<br><br>Survey Dates: January 23, 24, 25, 2023<br><br>Unduplicated Skilled Patient Census for past 12 Months: 782<br><br>Active Census: 212<br><br>During this revisit survey, two (2) deficiencies were found corrected.<br><br>QR: Area 2, 02/06/23 | N0000 | | 2023-02-14 |
| G0000 | INITIAL COMMENTS<br><br>This was a first Post Condition | G0000 | Effective immediately theAgency will complete all futureHome Health Aid CompetencyEvaluations and/or trainingunder contract with an areaagency that is licensed | 2023-02-14 |

| | | | | |
|---|---|---|---|---|
| | Revisit for a Federal and State Complaint Investigation survey completed on 11/29/2022.<br><br>Survey Dates: January 23, 24, 25; 2023<br><br>Unduplicated Skilled Patient Census for past 12 Months: 782<br><br>Active Census: 212<br><br>During this revisit survey, one (1) Condition level deficiency and seven (7) standard level deficiencies were found corrected, three (3) standard level deficiencies were re-cited, and one (1) standard level deficiency was newly cited.<br><br>Based on the Condition-level deficiencies during the November 29, 2022 survey, Hoosier Homecare Services was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on November 29, 2022. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, the agency continues to be 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 November 29, | | toperform such duties from11/29/22 to 11/28/24. This willbe implemented and followedby the Director of Nursing withsupport from Human Resourcesto identify the annual deadlinefor all current home health aideCompetency Evaluations. | |

| | | | | |
|---|---|---|---|---|
| | 2022 and continuing through November 28, 2024.<br><br>This deficiency report reflects State Findings cited in accordance with 410 IAC 17.<br><br>QR: Area 2, 02/07/23 | | | |
| G0536 | A review of all current medications<br><br>484.55(c)(5)<br><br>A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.<br><br>Based on observation, record review, and interview, the home health agency failed to follow their policy for the the patient's medication profile; failed to include all active medications, the frequency of administration and the accurate dose for all medications, and failed to include the indications for PRN (as needed) medications for 3 of 5 active patient records reviewed (Patient # 13, 14, 15).<br><br>2. During a home visit conducted on 01/24/2023 at 12:00 PM with Patient #13 (start of care 11/09/2022), the patient's medications were | G0536 | A Review of AllCurrent Medications: To ensure 100% compliance, stafftraining was completed by theDirector of Nursing for allclinicians conductingmedication entries on01/31/23. Training during thissession included review ofagency policy on"MedicationProfile" and education onmedication entry into patient'srecord, as well as, entry of"PRN" or "asneeded" medications with thelisting of the indication forthese medications. Clinicians were educated that all medications, including over-the counter medications, herbs and supplements must be included. The components of themedication profile werereviewed to include dose,frequency, and route. All clinicians are required tointerview the patient orcaregiver at each visit to identifymedication changes or newmedications. This interview is arequired component of eachvisit and will be monitored forcompliance by theAdministrator, AlternateAdministrator, and Director ofNursing. It will be theresponsibility of the Directorof Nursing to conduct reviews ofeach medication profilesubmitted to ensure 100%compliance that eachmedication has been identifiedand has the appropriateindication and frequency.The clinician will notify theDirector of Nursing of anymedication change entered for apatient and any identifiedinteractions. Verification of thisoversight will be evidenced bythe Director of Nurse'sinitials/date on the medicationprofile. The Director of Nursing will complete random audits of patient's medication profiles, with a minimum of 10 quarterly, to verify accuracy of the patient's medication profile. The findings will be reported to QAPI quarterly. The D.O.N., Administrator, and Alternate Administrator will | 2023-01-31 |

| | | | | |
|---|---|---|---|---|
| | reviewed with the patient against the medication list provided by the agency. The medication list indicated Patient #13 was taking Norco 5-325 mg (opioid narcotic given to treat pain) however a bottle of Norco 7.5-325 mg was observed in the patient's home. A bottle of Norco 5-325 mg was not observed in the patient's home. Patient #13 reported their dose of Norco increased from 5-325 to 7.5-325 prior to starting with home care. Patient #13's observed medications also included a bottle of Gavilax powder (given to treat constipation), dated as picked up on 10/10/2022, which the patient reported they used as needed for constipation. The patient stated a Hoosier Homecare nurse had found the bottle of Gavilax in the patient's home and had advised the patient to take the medication as needed for constipation. The patient could not recall the nurse's name. Review of Patient #13's medication list failed to evidence the correct dose or Norco and failed to evidence Gavilax.<br><br>3. During a home visit | | be responsible for reviewing all submitted documentation for inclusion of the patient/caregiver interview related to questioning if the patient has had any medication changes since the last home health visit. | |

| | | | | |
|---|---|---|---|---|
| | 1:30 PM with Patient #14 (start of care 11/25/2022), the patient's family member reported to Licensed Practical Nurse (LPN) #2 the patient was now taking Toujeo (non-insulin medication given by injection to treat diabetes) 10 units every day. The medication was dated as picked up on 01/13/2023. The patient's family member stated she had previously informed Physical Therapist #2 of the new medication. The family member also reported the patient had not received Lantus (long-acting insulin given to treat diabetes) since being in a nursing facility prior to starting home health services. Review of Patient #14's medication list indicated Patient #14 was still taking Lantus and failed to evidence Toujeo.<br><br>An interview was conducted on 01/25/2023 at 12:18 PM with Physical Therapist #2. During the interview, PT #2 stated Patient #14's family member had not reported the patient had started taking Toujeo during their last visit with the patient (01/16/2023).<br><br>An interview was conducted on | | | |

| | | | | |
|---|---|---|---|---|
| | Registered Nurse (RN) #1. During the interview, the nurse reported they completed a medication reconciliation during the recertification assessment on 01/20/2023 by asking Patient #14's family member if there were any medication changes. RN #1 stated the family member declined any medication changes at that time.<br><br>Findings included:<br><br>1. Policy C-700 titled "Medication Profile" included but not limited to "... The Nurse/ Therapist shall record on the Medication Profile all prescribed and over-the-counter (OTC) medications the patient is currently taking... 3. The Medication Profile shall document: ...c. Medication name (full name with no abbreviations)... d. Medication dosage (using only accepted abbreviations)... e. Route and frequency of administration... 5. If the physician changes the medication orders, the Nurse/ Therapist must add newly | | | |

| | | | | |
|---|---|---|---|---|
| | ordered drugs or medication changes to the Medication Profile...10. 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..."<br><br>4. Review of the clinical record for Patient #15, SOC 12/20/2022, included a medication profile, completed as part of the nursing assessment. The medication list included but not limited to "...Bacitracin External 500 UNIT/ GM Sm amount Apply to insertion site of suprapubic catheter..." The medication profile failed to include the frequency for this medication.<br><br>5. During an interview on 01/24/2023 at 04:11 PM, the Director of Nursing indicated the Medication Profile should have included for each medication the medication name, dosage, frequency, and route. During the same interview, the Administrator indicated the Medication Profile should have also included indications for PRN (as needed) medications, and the | | | |

| | | | | |
|---|---|---|---|---|
| | medications the patient was taking should have been in the Medication Profile as longer as the patient informed the clinician of the medication when asked about medication changes.<br><br>410 IAC 17-14-1(a)(1)(B) | | | |
| G0572 | Plan of care<br><br>484.60(a)(1)<br><br>Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan.<br><br>Based on record review and interview, the home health agency failed to ensure the plan of care was individualized for 5 of 8 records reviewed (Patients #13, 14, 15, 17, 20).<br><br>Findings include:<br><br>1. Policy #C-580 titled “Plan of Care” indicated but was not | G0572 | To ensure 100% compliance in resolving this deficiency all staff training was completed by the Administrator on 02/07/23 regarding the completion of orders for additional disciplines. The ordering clinician will identify the discipline ordered/needed and the indication or reason for the discipline. Additionally, an individualized statement will also be included, on the Plan of Care/485, to recognize the evaluating discipline (PT, OT, and/or ST) and declare the evaluation/assessment as an Addendum to the Physician Plan of Care/485. The Addendum(s) will be sent to the Physician for review and signature. The Director of Nursing, Administrator, and Alternate Administrator will be responsible for ensuring compliance by review and approval of all submitted documentation. Agency Policy "Care Plans" C-660 has been updated and approved by the Governing Body as of 02/14/23. | 2023-02-07 |

| | | | | |
|---|---|---|---|---|
| | of Care is based on a comprehensive assessment and information provided by the patient/family and health team members ... Special Instructions: 1. An individualized Plan of Care signed by a physician/allowed practitioner shall be required for each patient receiving home health and personal care services ...."<br><br>2. Review of clinical record for Patient #13, start of care (SOC) 11/09/2022, included a plan of care for recertification period 01/08/2023 – 03/08/2023. The plan of care indicated Patient #13 was to receive physical therapy and home health aide services. The plan of care also indicated but was not limited to "... In the event that Therapy Assessments (Physical, Occupational, Speech) are completed during the Start of Care, Recertification, or Resumption of Care, these Assessments will be considered Addendum(s) to the Home Health Certification and Plan of Care. See Therapy Assessment(s) for discipline specific Plan of Care ...." The plan of care failed to be individualized. | | | |

| | | | | |
|---|---|---|---|---|
| | 3. Review of the clinical record for Patient #14, SOC 11/25/2022, included a plan of care for the recertification period 01/24/2023 – 03/24/2023. The plan of care indicated Patient #14 was to receive occupational therapy and skilled nursing services. The plan of care also indicated but was not limited to "… In the event that Therapy Assessments (Physical, Occupational, Speech) are completed during the Start of Care, Recertification, or Resumption of Care, these Assessments will be considered Addendum(s) to the Home Health Certification and Plan of Care. See Therapy Assessment(s) for discipline specific Plan of Care …." The plan of care failed to be individualized.<br><br>6. Review of the clinical record for Patient #20, SOC 01/02/2023, included a plan of care for the initial certification period 01/02/2023 – 03/02/2023. The plan of care indicated Patient #20 was to receive skilled nursing and physical therapy services. The order for physical therapy services stated "eval and treat" which failed to evidence the | | | |

| | | | | |
|---|---|---|---|---|
| | specific condition(s) or issues the therapist was to evaluate and treat. The plan of care also indicated but was not limited to "... In the event that Therapy Assessments (Physical, Occupational, Speech) are completed during the Start of Care, Recertification, or Resumption of Care, these Assessments will be considered Addendum(s) to the Home Health Certification and Plan of Care. See Therapy Assessment(s) for discipline specific Plan of Care ...." The plan of care failed to be individualized.<br><br>7. An interview was conducted on 01/25/2023 at 3:18 PM. When queried how the therapist would know what issue(s) or concern(s) to evaluate and treat when the service order for therapy only stated "eval and treat," the Administrator stated the therapist would communicate with the admitting case manager and also had access to the patient's history and physical records. The Administrator confirmed the statement which began with "In the event that Therapy Assessments ..." was included in | | | |

| | | | | |
|---|---|---|---|---|
| | with therapy services as a part of the agency's Plan of Corrections for the survey completed on 11/292022. When queried as to why this statement was not specified to the actual therapy(ies) the patient was to receive, the Administrator reported the Plan of Care did include the service order(s) for therapy(ies) and the purpose of the statement was to indicate the therapy assessment(s) was/were considered plan of care addendum(s).<br><br>Review of clinical record for Patient #15, SOC 12/20/2022, included a plan of care for certification period 12/20/2022 – 02/17/2023. The plan of care indicated Patient #15 was to receive skilled nursing, physical therapy, occupational therapy, and home health aide services. The plan of care also indicated but was not limited to "… In the event that Therapy Assessments (Physical, Occupational, Speech) are completed during the Start of Care, Recertification, or Resumption of Care, these Assessments will be considered Addendum(s) to the Home Health Certification and Plan of | | | |

| | | | | |
|---|---|---|---|---|
| | Assessment(s) for discipline specific Plan of Care ….” The plan of care failed to be patient-specific.<br><br>Review of the clinical record for Patient #17, SOC 01/16/2023, included a plan of care for the certification period 01/16/2023 – 03/16/2023. The plan of care indicated Patient #17 was to receive physical therapy, occupational therapy and home health aide services. The plan of care also indicated but was not limited to “… In the event that Therapy Assessments (Physical, Occupational, Speech) are completed during the Start of Care, Recertification, or Resumption of Care, these Assessments will be considered Addendum(s) to the Home Health Certification and Plan of Care. See Therapy Assessment(s) for discipline specific Plan of Care ….” The plan of care failed to be patient-specific. | | | |
| G0620 | Other pertinent instructions<br><br>484.60(e)(4)<br><br>Any other pertinent instruction related to the patient's care and treatments that the HHA will | G0620 | To ensure 100% compliance the Administrator completed all staff training on 02/14/23 to educate clinicians that a copy of the current Plan of Care/485, and Home Health Aide Care Plan (if applicable) must be provided to all patients. The Administrative Assistant will be responsible for printing all current patients' Plan of Care/485's and Home Health Aide Care Plans. The Administrative Assistant will identify | 2023-02-14 |

| | | | | |
|---|---|---|---|---|
| | provide, specific to the patient's care needs.<br><br>Based on observation, record review, and interview, the home health agency failed to ensure all patients were provided a plan of care for 2 of 2 home visit observations (Patients #13, 14) and failed to ensure patients receiving home health aide services received a home health aide care plan for 1 of 1 home visit observations of a patient receiving home health aide services (Patient #13).<br><br>Findings include:<br><br>1. Policy #C-660, titled "Care Plans," indicated but was not limited to "... If the patient has specific complex care needs that require specific direction in the home, an individualized treatment plan will be left in the home ...." | | the Case Manager for each patient and will provide paper copies of the documents to be delivered to the patients' homes no later than 02/23/23. The Administrator will review the current patient roster "check off list" to ensure compliance. The Administrative Assistant will be responsible for printing all future Plan of Cares and Home Health Aide Care Plans developed to give to the Case Manager(s) for delivery to the patient home within 10 days of the beginning of the certification period. The Agency's policy C660 titled "Care Plans" has been updated to include the procedure to print and deliver these documents. The Governing Body approved the updated policy on 02/14/23. Random visits will be made by the D.O.N. or A.D.O.N. quarterly to ensure 100% compliance with this standard. | |

| | | | | |
|---|---|---|---|---|
| | 2. During a home visit conducted on 01/24/2023 at 12:00 PM with Patient #13 and Home Health Aide #1 the patient's home folder was reviewed. The home folder failed to evidence a plan of care nor an aide care plan. Patient #13 was queried during the home visit whether they had received a plan of care or aide care plan from the agency and the patient indicated they had not received either plan.<br><br>3. During a home visit conducted on 01/24/2023 at 1:30 PM with Patient #14 and Licensed Practical Nurse #2 the patient's home folder was reviewed. The home folder failed to evidence a plan of care. Patient #14's family member (who was also the patient's primary caregiver) was queried during the home visit whether they had received a plan of care from the agency and the family member indicated they had not received the plan of care.<br><br>4. An interview was conducted on 01/24/2023 beginning at 4:11 PM with the Administrator and Clinical Manager. When queried if the patient home folder should include the | | | |

| | | | | |
|---|---|---|---|---|
| | patient's current plan of care, the Administrator provided agency policy #C-660. The Administrator confirmed the agency's policy indicated that agency was only required to keep a plan of care in the patient's home if the patient had "complex care needs that require specific direction." The Administrator also confirmed the agency did not provide written home health aide care plans to patients who received home health aide services. | | | |
| G0800 | Services provided by HH aide<br><br>484.80(g)(2)<br><br>A home health aide provides services that are:<br>(i) Ordered by the physician or allowed practitioner;<br>(ii) Included in the plan of care;<br>(iii) Permitted to be performed under state law; and<br>(iv) Consistent with the home health aide training. | G0800 | To ensure 100% compliance with this standard, the Administrator and the Director of Nursing trained all staff on 01/31/23, including the home health aide staff, on the requirement to document, on each Home Health Aide Visit Note, the completion or non-completion of all tasks assigned on the Home Health Aide Care Plan. All tasks assigned, whether performed at "each visit" or "as directed by the patient/caregiver" will be documented as completed or declined to ensure that all tasks have been reviewed, are on the aide care plan, and the outcome of the task documented. The Director of Nursing will be responsible for reviewing all Home Health Aide Visit notes to ensure ongoing compliance for this requirement. The Director of Nursing will be responsible for training any new employees hired regarding this requirement. | 2023-01-31 |

Based on observation, record review, and interview, the home health agency failed to ensure the home health aide provided services that were ordered and included in the aide care plan for 2 of 2 active patients who received aide services (Patient #13, 15.)

2. Clinical record review for Patient #13 included a plan of care for the recertification period 01/08/2023 – 03/08/2023 which indicated the patient was to receive physical therapy and home health aide services. The record included an aide care plan which indicated the aide was to complete the tasks of incontinent care, assist in ambulation, light housekeeping, comb hair, and shampoo hair were to be completed as needed "as directed by" the patient or caregiver. The record indicated Home Health Aide #1 conducted home health aide visits on 01/10/2023, 01/12/2023, 01/17/2023, and 01/20/2023. The visit notes failed to evidence the aide offered and/or completed the as needed tasks.

4. During an interview conducted on 01/24/2023 beginning at 12:38 PM, Home

Health Aide #1 confirmed they would not document if a patient declined an as needed task.

Findings include:

1. Review of agency document titled “Position: Home Health Aide” indicated but not limited to “…Essential Functions/ Areas of Accountability… Completes the appropriate records to document care given and pertinent observations…”

3. Clinical record review for Patient #15 indicated an aide care plan for the certification period 12/20/2022 – 02/17/2022 indicated but not limited to the tasks of assist with bedside commode, assist in ambulation, assist in transfer, comb hair, foot care, nail care, partial bath/ sponge, shampoo hair, and shave, all marked "Prn [as needed] as directed by pt [patient]/ caregiver and change linen and make bed marked as "per pt/ cg [caregiver] request." HHA #1 failed to indicate whether all of these tasks were either completed or the patient declined for the following visit dates: 12/21/2022, 12/27/2022, 12/29/2022, 01/03/2023, 01/05/2023, 01/09/2023,

| | | | | |
|---|---|---|---|---|
| | 01/12/2023, 01/16/2023, 01/19/2023, and 01/23/2023.<br><br>5. During an interview on 01/25/2023 beginning at 03:18 PM, the Administrator and the DON both indicated the aide is to interview the patient at every visit regarding each PRN task but is not expected to document that a patient declined a PRN task.<br><br>410 IAC 17-14-1(h)(2) | | | |

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 |
|---|---|---|
| Christopher E Daggy | Administrator | 2/21/2023 11:29:33 AM |