

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157710 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 06/09/2023 |
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| NAME OF PROVIDER OR SUPPLIER PRAIRIE HEALTHCARE SERVICES LLC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5920 HOHMAN AVENUE, HAMMOND, IN, 46320 | |
| (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 survey was a State re-licensure for a home health agency conducted by the Indiana Department of Health (IDOH). Survey Dates: 6/6/2023 – 6/9/2023 Facility ID: 014328 Census: 16 Quality Review Completed 06/20/2023 | N0000 | | |
| N0458 | Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to | N0458 | In-Service Training was conducted to all staff on 06/23/2023 and reviewed Policies and Procedures regarding personnel's Annual Performance Evaluation based on specific job descriptions. The result of the Annual Performance Evaluation will be shared | 2023-06-23 |

perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:

- (1) Receipt of job description.
- (2) Qualifications.
- (3) A copy of limited criminal history pursuant to IC 16-27-2.
- (4) A copy of current license, certification, or registration.
- (5) Annual performance evaluations.

Based on record review and interview, the agency failed to ensure every employee had a performance evaluation within the last 12 months for 2 of 6 personnel records reviewed (alternate administrator, home health aide #1).

The findings include:

- 1. Record review of an agency policy titled "Personnel Records" revised 11/4/2022, stated "... The personnel record or personnel information for an employee will include, but not be limited to ... Performance appraisal/evaluation forms...."
- 2. Personnel record review on 6/6/2023, for the alternate administrator, hire date of 11/27/2017, failed to evidence a performance evaluation was conducted within the last 12 months.

by the supervisor to the involved personnel.

The ADMINISTRATOR will be using developed H.R audit tool in reviewing 100% of the agency's personnel files on a monthly basis starting **07/10/2023 for 3 consecutive months** to ensure ALL personnel Performance Evaluations are completed, shared, reviewed and signed by the supervisor and employee on an annual basis. Our agency's target threshold for compliance is **100% by 09/10/2023**. Once the threshold is met, H.R audit will be annually to ensure the agency is in compliance with the agency policy and licensure requirement. Summary of H.R Audit on a monthly basis will be reported to Governing Body and will be shared to all staff during Quarterly Meetings.

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| | <p>3. Personnel record review on 6/6/2023, for home health aide #1, hire date of 3/15/2022, failed to evidence a performance evaluation was conducted within the last 12 months.</p> <p>4. During an interview on 6/6/2023, at 3:43 PM, the administrator indicated the agency became too relaxed and fell behind on performance evaluations after a survey from Entity 2 a few months ago.</p> | | | |
| <p>N0488</p> | <p>Q A and performance improvement</p> <p>410 IAC 17-12-2(i) and (j)</p> <p>Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped.</p> <p>(j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances:</p> <p>(1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient.</p> <p>(2) The patient refuses the home health agency's services.</p> <p>(3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or</p> <p>(4) The patient no longer meets applicable regulatory</p> | <p>N0488</p> | <div style="border: 1px solid black; padding: 10px;"> <p>The Clinical Manager revised the age provided In-Service Training to all clinical procedures in regard to the process of the patient's Discharge Planning.</p> <p>The Clinical Manager will be using the implementation of effective, appropriate Discharge Planning. Starting 07/10/23 the agency's discharge patient medication threshold for compliance is 100% by 08/31/23 be done quarterly with 50% of the age Licensure requirement. Summary of Clinical</p> </div> | <p>2023-06-23</p> |

criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.

Based on record review and interview, the agency failed to ensure a 15-day discharge notice policy was developed and implemented for 1 of 1 planned discharged record reviewed (patient #6).

The findings include:

Record review of an agency policy titled "Patient Bill of Rights and Responsibilities" revised 11/4/2022, stated "Patients have the right: ... Receive proper written notice, in advance of a specific service being furnished...."

Record review of an agency policy titled "Discharge Criteria" revised 11/4/2022, stated "... The patient is informed of discharge plan in a timely manner and acknowledges

planning begins at time of admission and will be reflected in the documentation....”

Record review on 6/6/2023, of the agency’s patient admission folder evidenced planned discharge information which indicated the agency would provide a 5-day discharge notice to the patient.

Clinical record review on 6/9/2023, for patient #6, start of care 10/29/2022, evidenced a discharge assessment occurred on 4/21/2023. Record review failed to evidence the patient received a 15-day discharge notice.

Record review failed to evidence an agency discharge policy to establish and implement a 15-day discharge notice.

During an interview on 6/9/2023, at 2:27 PM, the QAPI Coordinator indicated they will work to implement a 15-day discharge policy moving forward.

During an interview on 6/6/2023, at 3:54 PM the QAPI (quality assurance performance improvement) Coordinator indicated the agency would provide the planned discharge notice at least a week prior to the discharge visit.

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| <p>N0524</p> | <p>Patient Care</p> <p>410 IAC 17-13-1(a)(1)</p> <p>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <ul style="list-style-type: none"> (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. <p>Based on record review and interview, the agency failed to ensure the plan of care was individualized to include affected areas for topical medications for 3 of 4 active clinical records reviewed where topical medications were ordered (patient</p> | <p>N0524</p> | <div style="border: 1px solid black; padding: 5px;"> <p>The Clinical Manager reviewed policies with clinicians on 06/23/2023 regarding accurate topical medications, address the specific location of the</p> <p>The Clinical Manager will be using the implementation of accurate and proper 07/10/2023, the Clinical Manager will discharge patient medical records for compliance is 100% by 09/10/2023. C quarterly with 50% of the agency's patients with the Licensure requirement. Summary to Governing Body and will be shared</p> </div> | <p>2023-06-23</p> |
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#2, #3, #5).

The findings include:

1. Record review of an agency policy titled "Plan of Care – CMS #485 and Physician Orders" revised 11/4/2022, stated "... Each patient receiving home health services must receive an individualized written plan of care, including any revisions or additions ... The individualized plan of care must include the following: ... All medications and treatments...."

2. Clinical record review on 6/7/2023, for patient #2, start of care 4/25/2023, of an agency document titled "Home Health Certification and Plan of Care" indicated the patient was ordered the topical medications Diclofenac Sodium Gel (used to relive pain in joints) and Ammonium Lactate (used to treat dry or scaly skin). The directions for use of the topical medications stated "... Application to affected area" This document failed to evidence indications where the affected area was for the patient.

During an interview on 6/9/2023, at 1:46 PM, the QAPI (quality assurance performance improvement) Coordinator indicated the specific location for topical medications should have been addressed on the plan of care.

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| | <p>3. Clinical record review on 6/7/2023, for patient #3, start of care 5/18/2023, of an agency document titled "Home Health Certification and Plan of Care" indicated the patient was ordered the topical medication Econazole Nitrate Cream (used to treat fungal infections) and directions for use stated "... Application to affected area" This document failed to evidence indications where the affected area was for the patient.</p> <p>4. Clinical record review on 6/7/2023, for patient #5, start of care 1/8/2023, of an agency document titled "Home Health Certification and Plan of Care" indicated the patient was ordered the topical medication Bactroban Ointment (antibiotic topical medication) and directions for use stated "... Application once a day on affected body part until healed" This document failed to evidence indications where the affected area was for the patient.</p> <p>5. During an interview on 6/9/2023, at 1:09 PM, the QAPI Coordinator indicated the instructions for topical medications should include the specific area where medication is to be applied.</p> | | | |
| N0533 | <p>Nursing Plan of Care</p> <p>410 IAC 17-13-2</p> | N0533 | <p>The Clinical Manager reviewed policies with clinicians on 06/23/2023 regarding the</p> | 2023-06-23 |

Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service.

(b) The nursing plan of care must contain the following:

- (1) A plan of care and appropriate patient identifying information.
- (2) The name of the patient's physician.
- (3) Services to be provided.
- (4) The frequency and duration of visits.
- (5) Medications, diet, and activities.
- (6) Signed and dated clinical notes from all personnel providing services.
- (7) Supervisory visits.
- (8) Sixty (60) day summaries.
- (9) The discharge note.
- (10) The signature of the registered nurse who developed the plan.

Based on record review and interview, the agency failed to ensure the home health aide (HHA) performed tasks according to the care plan for 2 of 2 clinical records reviewed where HHA services were provided (patient #1, #6).

The findings include:

- 1. Record review of an agency policy titled "Home Health Aide Supervision"

for the purpose of delegating nursing for patients receiving only home health

The Clinical Manager educated our R document all necessary household tas

The **Clinical Manager** re-oriented Hor properly document tasks according to

The **Clinical Manager** will be using the implementation of Nursing Plan of Care discharge patient medical records. The consecutive months to ensure the Hor tasks in the written Nursing Care Plan. the threshold is met, the clinical record patient records and discharged record

Summary of Clinical Record Audit on a be shared to all staff during Quarterly

To assure the appropriateness of home health aide services and to maintain quality of care ... Procedure ... Home Health Aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to ... Following the patient's plan of care for completion of tasks assigned to a Home Health Aide by the registered nurse or other appropriate skilled professional"

2. Record review of an agency policy titled "Home Health Aide Documentation" revised 11/4/2022, stated "Purpose ... To provide documentation of the care performed by the Home Health Aide (HHA) on each visit ... Procedure ... The Home Health Aide will document services rendered to the patient on the appropriate Home Health Aide charting form as directed in the Aide care plan/assignment sheet".

3. Clinical record review on 6/7/2023, for patient #1, start of care 4/13/2023, evidenced an agency document titled "HHA Care Plan" which failed to evidence household tasks were assigned to the HHA.

Record review of HHA visit notes evidenced household tasks were refused on 4/18/2023, 4/20/2023, 4/27/2023, 5/2/2023, 5/4/2023,

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| | <p>6/1/2023.</p> <p>3. Clinical record review on 6/7/2023, for patient #6, start of care 10/29/2022, evidenced an agency document titled "HHA Care Plan" which failed to evidence household tasks were assigned to the HHA.</p> <p>Record review of HHA visit notes evidenced household tasks were refused on 3/14/2023, 4/11/2023, and 4/18/2023.</p> <p>4. During an interview on 6/9/2023, at 1:33 PM, the QAPI Coordinator indicated the patient could not refuse something that was not ordered.</p> | | | |
| <p>N0542</p> | <p>Scope of Services</p> <p>410 IAC 17-14-1(a)(1)(C)</p> <p>Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:</p> <p>(C) Initiate the plan of care and necessary revisions.</p> <p>Based on record review and interview, the agency failed to ensure the plan of care was revised as necessary for subsequent orders for 2 of 5 clinical records reviewed (patient #3, #5).</p> | <p>N0542</p> | <p>The Clinical Manager reviewed policies and procedures and provided In-Service Training to all clinicians on 06/23/2023 regarding the Scope of Services. The Registered Nurse or Therapist responsible for furnishing or supervising ordered services must initiate the plan of care and necessary revisions or additions. All new or changes in medication orders and/or frequency of visits must be documented in the Physician Order as an ADDENDUM TO THE PLAN OF CARE.</p> | <p>2023-06-23</p> |

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| <p>The findings include:</p> <p>1. Record review of an agency policy titled "Plan of Care – CMS #485 and Physician Orders" revised 11/4/2022, stated "... Each patient receiving home health services must receive an individualized written plan of care, including any revisions or additions ... Verbal orders are put in writing, signed, timed and dated with the date of receipt by a RN [registered nurse] or therapist responsible for furnishing or supervising ordered services. It is the RN's or therapist's responsibility to make any necessary revisions to the Plan of Care based on that order(s)"</p> <p>2. Clinical record review on 6/7/2023, for patient #3, start of care 5/18/2023, evidenced an agency document titled "Physician Order" dated 5/25/2023, which indicated the patient's dosage of Lantus (diabetic medication used to prevent low blood sugar) was changed from 40 units nightly to 15 units nightly. This document failed to evidence the order was an addendum to the plan of care.</p> <p>Record review of an agency document titled "Physician Order" dated 5/31/2023, indicated the patient was prescribed Levofloxacin (antibiotic medication) for 10 days, and Fosfomycin (antibiotic medication) 1 pack weekly for 6 weeks. This</p> | <p>The Clinical Manager will be using the developed Clinical Chart Audit Tool to monitor the ONGOING implementation of Initiation of Plan of Care and necessary revisions (ADDENDUM TO THE PLAN OF CARE). Clinical Record Audit of 100% of the agency's active and discharge patient medical records on a monthly basis starting 07/10/2023 for 3 consecutive months to ensure that our clinicians will document an ADDENDUM TO THE PLAN OF CARE for any new or changes in medication(s) order and/or frequency of home health visits.</p> <p>Target threshold for compliance is 100% by 09/10/2023. Once the threshold is achieved, the clinical records audit will be done quarterly with 50% of the agency's active patient records and discharged records to ensure compliance with the licensure requirement. Summary of Clinical Record Audit on a monthly basis will be reported to the Governing Body and will be shared to all staff during Quarterly Meetings.</p> |
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was an addendum to the plan of care.

Record review of the agency document titled "Home Health Certification and Plan of Care" for certification 5/18/2023 – 7/16/2023, failed to evidence the plan of care was revised as necessary.

During an interview on 6/9/2023, at 1:49 PM, the QAPI (quality assurance performance improvement) Coordinator indicated medication profile was updated but not on the plan of care.

3. Clinical record review on 6/7/2023, for patient #5, start of care 1/8/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/8/2023 – 7/6/2023, which indicated the frequency order for skilled nurse visits was twice a week for 9 weeks.

Record review of an agency document titled "Physician Order" from 5/17/2023, indicated the patient would be seen 3 times weekly until the patient could return to the wound clinic. This document failed to evidence the order was an addendum to the plan of care. Record review failed to evidence the plan of care was revised as necessary.

4. During an interview on 6/9/2023, at

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| | <p>performance improvement) Coordinator indicated the process to make revisions on the plan of care was through the comprehensive assessment and would generate onto the next plan of care. The QAPI Coordinator explained if changes were made to the plan of care during the certification period, the agency would obtain a verbal order from the physician.</p> | | | |
| <p>N0544</p> | <p>Scope of Services</p> <p>410 IAC 17-14-1(a)(1)(E)</p> <p>Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:</p> <p>(E) Prepare clinical notes.</p> <p>Based on record review and interview, the agency failed to ensure the skilled nurse prepared clinical documentation for all wound care provided to patients in 1 of 2 active clinical records reviewed where wound care was indicated (patient #2).</p> <p>The findings include:</p> <p>Record review of an agency policy titled "Nursing Services" revised 11/4/2022, stated "...Professional nursing service will be provided by a registered nurse and include: ... Providing those services and/or</p> | <p>N0544</p> | <div style="border: 1px solid black; padding: 5px;"> <p>The Clinical Manager reviewed policies with clinicians on 06/23/2023 regarding Pre documentation for all wound care provided to the patient, other disciplines involved in patient's needs or medical status updates.</p> <p>The Clinical Manager will be using the implementation of Preparation of Clinical Chart Audit to 100% of the active and discharged patient records of Clinical Record Audit on a monthly basis with staff during Quarterly Meetings.</p> </div> | <p>2023-06-23</p> |

treatments requiring substantial and specialized nursing skill ... Preparing clinical notes ... Informing the physician and other staff of changes in the patient's needs"

Clinical record review for patient #2, start of care 4/25/2023, of an agency document titled "SN [skilled nurse] Teaching/Training Visit" dated 5/4/2023, evidenced care coordination was conducted with the physician and clinical supervisor. This section had an area that stated "... Pressure ulcer stage 2 on [his/her] left gluteal area, received order for wound treatment...."

Record review of skilled nurse visit notes from 5/11/2023, 5/25/2023, and 5/31/2023, failed to evidence wound care assessment and treatment.

During an interview on 6/9/2023, at 1:08 PM, the QAPI Coordinator indicated the wound care flowsheet within the nursing visit note should include the location, size, treatment, and narrative to describe wound care and how the patient responded.

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| | <p>During an interview on 6/9/2023, at 1:43 PM, the QAPI (quality assurance performance improvement) Coordinator indicated the patient did not currently have a wound and could not locate a physician order or communication to indicate the wound had resolved.</p> | | | |
| <p>N0565</p> | <p>Scope of Services</p> <p>410 IAC 17-14-1(c)(4)</p> <p>Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall:</p> <p>(4) help develop the plan of care (revising as necessary);</p> <p>Based on record review and interview, the agency failed to ensure the plan of care was revised to include physical therapy (PT) treatments and services for 2 of 2 active clinical records reviewed who received PT services (patient #1, #2).</p> <p>The findings include:</p> <p>1. Record review of an agency policy titled "Plan of Care – CMS #485 and Physician Orders" revised 11/4/2022, stated "... Each patient receiving home health services must receive an individualized written plan of care, including any revisions or additions ... It is the RN's or therapist's</p> | <p>N0565</p> | <p>The Clinical Manager reviewed policies Therapists on 06/23/2023 regarding A as necessary. Each Therapy Plan of Care services. All Therapy Care Plans must be recommended by the Therapists.</p> <p>The Clinical Manager will be using the implementation of</p> <p>Appropriate Therapist help develop the the Clinical Manager will perform Char medical records for 3 consecutive months 09/10/2023. Once the threshold is achieved the agency's patient active and discharge requirement. Summary of Clinical Recc and will be shared to all staff during Q</p> | <p>2023-06-16</p> |

responsibility to make any necessary revisions to the Plan of Care based on that order(s)”

2. Clinical record review on 6/7/2023, for patient #1, start of care 4/13/2023, evidenced an agency document titled “PT Plan of Care” which was electronically signed by physical therapist (PT) 3 on 5/4/2023. Record review failed to evidence the Plan of Care was revised to include treatments provided by PT services.

During an interview on 6/9/2023, at 1:27 PM, the QAPI (quality assurance performance improvement) Coordinator indicated the physician signed the PT evaluation instead of the PT Plan of Care.

3. Clinical record review on 6/7/2023, for patient #2, start of care 4/25/2023, of an agency document titled “PT Plan of Care” which was electronically signed by PT 2 on 4/28/2023. Record review failed to evidence the Plan of Care was revised to include treatments provided by PT services.

4. During the entrance conference on 6/6/2023, which occurred from 10:17 AM – 10:47 AM, the QAPI Coordinator indicated the agency considered the plan of care to include but not limited to PT and Occupational Therapy (OT) plans of care.

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| <p>5. During an interview on 6/9/2023, at 1:11 PM, the QAPI Coordinator indicated the therapy plans of care were sent to the physician for signature to authorize the treatments recommended by the therapists.</p> | | | |
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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.

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| <p>LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE SHAHZAD KHAN</p> | <p>TITLE ADMINISTRATOR</p> | <p>(X6) DATE 6/27/2023 12:25:19 AM</p> |
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