STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2326841	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2024

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HOME CARE SERVICES OF NORTHWEST INDIANA	**240 Commerce Square Drive , Michigan City, Indiana, 46360**

(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 Re-Licensure survey of a Deemed Home Health Provider. Survey Dates: January 17, 18, 19, and 22, 2024 12-Month Unduplicated Skilled Admissions: 227 QR:01/26/2024 A 1	N0000		
N0470	Home health agency administration/management CFR(s): 410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure all employees followed standard precautions and infection control practices in 2 of 2 home visits conducted with a skilled nurse (Patient #1 and 3) and 1 of 1 record reviewed with a documented infection (Patient #8). The findings include: 1. A review of a policy titled “Exposure Control Plan: OSHA [Occupational Safety and Health Administration Regulations],” revised 7/2021, indicated bags used for carrying equipment into a patient’s home are classified as clean on the inside and the outside of the bag is considered soiled. The policy indicated the bag should be placed on a clean surface, hands washed before entering the bag, and used equipment cleaned before returning to the bag. 2. A review of a policy titled “Specific Procedures for Employee and Patient Infection Control Training”, revised 3/2018, indicated employees should wash their hands before applying and after removing gloves.	N0470		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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N0470	Continued from page 1 3. A review of a policy titled "Infection Control Plan", revised 3/2018, indicated the agency would establish and follow a plan for the ongoing surveillance of infections. 4. During a home visit observation for Patient #1 on 01/18/2024 at 9:35 AM, RN (Registered Nurse) 1 was observed and entered the home and placed their nurse bag on the counter without use of a barrier or before cleaning the counter. During an interview on 01/22/2024 at 11:35 AM, the Clinical Supervisor indicated when placing their nurse travel bag on a counter or table, the nurse should use a barrier. 5. During an observation of a home visit on 01/22/2024 beginning at 9:00 AM, Licensed Practical Nurse [LPN] 2 was observed as they removed Patient #3's colostomy (surgical opening in the intestines) bag, washed around the stoma with a wash cloth and water, then applied skin prep and adhesive powder, and reapplied a new drainage bag. Throughout the process, LPN 2 was observed to doff soiled gloves and don new gloves after removal of the soiled bag, after washing the stoma, after they applied skin prep and adhesive powder; LPN 2 failed to complete hand hygiene after removing their gloves and before donning new gloves throughout the process. During the observation of a home visit LPN 2 was observed and used a blood pressure machine and thermometer to take Patient's blood pressure and temperature and returned the blood pressure machine and the thermometer to their nurse travel bag without decontamination. During an interview on 01/22/2024, at 9:50 AM, Licensed Practical Nurse 2 indicated hands are to be washed before and after patient visits and they would cleanse equipment after they returned to the office. During an interview on 01/22/2024, at 3:05 PM, the Clinical Supervisor indicated a clinician should wash or sanitize hands after removal of gloves and equipment should be cleaned prior to returning to the nurses' bag. 6. A review of a plan of care for Patient #8, for the certification period 11/23/2023 - 01/21/2024 indicated Patient had tested positive for COVID (infectious viral respiratory illness).	N0470		

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N0470	Continued from page 2 A review of the infection control log on 01/22/2024 failed to evidence the patient's COVID infection. During an interview on 01/22/2024, at 11:24 AM, the Clinical Supervisor indicated a COVID infection should be on the infection control log and Patient was not on the log.	N0470		
N0522	Patient Care CFR(s): 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure care was provided as directed in the plan of care in 2 of 2 patient records with reported pain level greater than 7 (Patient #1 and 2) and 1 of 1 records reviewed that received home health aide services (Patient #4). The findings include: 1. A review of a policy titled "Plan of Care -- CMS [Centers for Medicare and Medicaid Services] #485 and Physician / Practitioners Orders", revised 4/2023 indicated each patient must receive care as written in an individualized plan of care. 2. A review of the plan of care for Patient #1, certification period 12/13/2023 to 2/10/2024, evidenced the nurse should perform the following tasks: Notify the physician if pain is greater than 7 out of 10, Assess the patient's breath sounds (listen to the chest / back with a stethoscope while the patient takes deep breaths), notify the physician if blood pressure is outside of range (Systolic greater than 180 or less than 90; Diastolic greater than 90 or less than 55), monitor peripheral pulses (feeling of the pulse in the arms, wrists, legs and/or feet), monitor for edema (swelling), and notify the physician of new edema. During a home visit observation on 01/18/2024 beginning at 9:35 AM, registered nurse [RN] 1 assessed Patient #1's blood pressure at 169/103. Throughout observation of the visit, RN 1 failed to notify the physician of the blood pressure outside of parameters and failed to assess Patient's breath sounds nor did RN 1 assess Patient's peripheral pulses and edema.	N0522		

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N0522	Continued from page 3 A review of skilled nurse visit notes dated 12/18/23 and 12/27/23, revealed Patient reported their pain level at greater than 7 during each visit; on 12/18/2023 they reported a pain rating of 8 and on 12/27/2023 they reported a pain rating of 9. Clinical record review failed to evidence the nurse notified the physician of Patient's pain. The skilled nurse visit note dated 12/27/2023 evidenced Patient had 2+ edema (a grading scale of edema is from 1+, mild to 4+, severe) to their right foot and 3+ edema to their left foot. The previous assessments indicated Patient had no edema. The clinical record failed to evidence the nurse notified the physician of the new edema. During an interview on 01/18/2024 at 9:59 AM, RN 1 indicated she did not need to notify the physician of Patient's elevated blood pressure because it was "pain pressure," and because of her background as a cardiology nurse, she did not get excited about it. RN 1 indicated she did not perform a full physical assessment because Patient was doing so well and would probably discharge in the next couple of weeks. When asked about the Patient's pain management, RN 1 indicated the pain was from osteoarthritis, not related to their heart surgery, and that Patient's family member had gotten different over the counter remedies for Patient. During an interview on 1/22/2024 at 11:27 AM, the Clinical Supervisor indicated the nurse should have assessed breath sounds and peripheral pulses as well as assess for edema at each visit and indicated if a blood pressure or pain rating is outside of parameters in the plan of care, the nurse should inform the physician and document the notification either in the visit note or in a communication note, and that pain should be reported regardless of the source of the pain. 3. A review of a plan of care for certification period 01/18/2024 - 3/17/2024 for Patient #2 indicated skilled nursing orders to include notification of physician if pain level is greater than 7 on a 0-10 pain scale (where 0 is no pain and 10 is worst pain). A review of an initial start of care comprehensive assessment dated 01/18/2024, indicated Patient had a pain level of 8, described as sharp pain with movement, lasting for hours and pain interfered with general daily activity, sleeping, ambulating. A review of the initial start of care assessment failed	N0522		

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N0522	Continued from page 4 to evidence the physician was notified of the pain level greater than 7 per the plan of care orders. During an interview on 01/22/2024, at 3:15 PM, the Administrator indicated the physician should be notified of pain levels outside of the plan of care parameters for physician notification. 4. A review of the plan of care for Patient #4, for certification period 12/15/2023 - 02/12/2024, included orders for home health aide services 1 time per week for 9 weeks and home health aide supervisory visits for management of care plan were to be completed every 14 days. A review of the aide visit notes indicated Patient had a home health aide visit on 12/12/2023, 12/19/2023, 12/26/2023, 01/02/2024, 01/09/2024, and 01/16/2024 and failed to evidence supervisory visits were completed by a skilled nurse. During an interview on 01/22/2024, at 12:15 PM, the Clinical Supervisor indicated there were not home health aide supervisory visits completed by a skilled nurse from 12/12/2023 - 01/16/2024.	N0522		
N0524	Patient Care CFR(s): 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. (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.	N0524		

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N0524	Continued from page 5 (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. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the plan of care included all current medications and equipment in 1 of 1 home visits with a registered nurse (Patient #1) and 1 of 1 records reviewed of a patient who used compression stockings (Patient # 8). The findings include: 1. A review of a policy titled “Plan of Care -- CMS [Centers for Medicare and Medicaid Services] #485 and Physician / Practitioners Orders”, revised 4/2023 indicated each patient would have an individualized plan of care which included all patient medications. 2. A review of the plan of care for certification period 12/13/2023 to 2/10/2024 evidenced Patient #1 took Lasix (a diuretic) and Ranolazine (a heart medication). During a home visit on 1/18/2023 at 9:51 AM, Patient #1’s home medication list was reviewed and failed to evidence Lasix and Ranolazine. The home medication list included the following medications not evidenced on the plan of care: Alphagan (eye drops for glaucoma), Vitamin D3, Docusate Sodium (a stool softener), Pantoprazole (a stomach acid reducer), Tramadol (a pain medication), and Tylenol (a pain medication). During an interview on 1/18/2023 at 9:55 AM, Patient #1 indicated the home medication list was current and correct. During an interview on 1/18/2023 at 9:59 AM, RN 1 indicated medications should be reconciled at start of care, recertification, and resumption of care visits as	N0524		

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N0524	Continued from page 6 well as when any medications are added or changed to ensure the clinical record matches what is in the home. 3. A review of the skilled nurse visit notes for Patient #8 and dated 12/07/2023, 12/14/2023, 12/21/2023, 12/28/2023, 01/04/2023, and 01/11/2024, indicated a pain rating of 4-6 on a 0-10 pain scale (0 was no pain and 10 was worst pain). During an interview on 01/19/2024 at 11:50 AM, Patient indicated the use of Tylenol (over the counter pain reliever) to control pain. A review of the plan of care for the certification period 11/23/2023 - 01/21/2024 and the medication profile received on 01/22/2024 failed to evidence Patient's use of Tylenol. During an interview on 01/22/2024 at 11:50 AM, the Clinical Supervisor indicated all medications Patient was taking and to include over the counter medication should be included on the plan of care. A review of a skilled nurse visits notes dated 12/07/2023, 12/14/2023, 12/21/2023, 12/28/2023 revealed Patient had swelling to their legs and used compression stockings (socks that squeeze the legs to improve blood flow) to the lower extremities daily. A review of the plan of care failed to evidence the use of compression stockings. During an interview on 01/22/2024 at 11:50 AM, the Clinical Supervisor indicated the use of compression stockings should be included on Patient's plan of care.	N0524		
N0527	Patient Care CFR(s): 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to promptly alert the physician to changes with the patient in 1 of 1 discharged record who received skilled nursing (Patient #6). Findings include:	N0527		

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N0527	Continued from page 7 1. A policy titled “Coordination of Patient Care”, revised 2/2021 indicated the agency must ensure communication with all physicians / practitioners involved in the plan of care. 2. A clinical record review evidenced Patient #6 was discharged on 12/20/2023 due to the patient’s request to end services. A review of the discharge summary, discharge visit note, and communication notes failed to evidence the physician was notified. During an interview on 1/22/2024 at 3:16 PM, the Clinical Supervisor indicated the nurse should inform the physician of the patient’s request for discharge and document the communication in the patient’s record.	N0527		
N0542	Scope of Services CFR(s): 410 IAC 17-14-1(a)(1)(C) 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: (C) Initiate the plan of care and necessary revisions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the registered nurse failed to revise the plan of care in 1 of 2 home visit observations of a skilled nurse (Patient #1). The findings include: 1. A policy titled “Nursing Services”, revised 2/2021, indicated the registered nurse would initiate the plan of care and make revisions as necessary. 2. During observation of a home visit on 1/18/2024 beginning at 9:32 AM, RN (Registered Nurse) 1 applied Desitin Extra Strength (a diaper cream) to Patient #1’s coccyx (tailbone) / buttocks area. No open areas were observed on the patient’s skin. A review of the plan of care for certification period 12/13/2023 to 2/10/2024 evidenced the nurse should perform the following coccyx wound care once a week: cleanse with saline, apply Venelex ointment (a topical medication for skin wounds), and cover with a border adhesive gauze. The plan of care failed to evidence using Desitin.	N0542		

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N0542	Continued from page 8 During an interview on 1/18/2024 at 9:48 AM, RN 1 indicated the Patient's wound had been healed for several weeks, and the Desitin Extra Strength was working very well. During an interview on 1/22/2024 at 11:33 AM, the Clinical Supervisor indicated the nurse should update the plan of care with any change in treatment or medications.	N0542		
N0544	Scope of Services CFR(s): 410 IAC 17-14-1(a)(1)(E) 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: (E) Prepare clinical notes. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, the registered nurse failed to document complete and accurate clinical notes in 2 of 6 active records reviewed (Patient #1 and 5). The findings include: 1. A policy titled "Medical Record Content", revised 4/2023, indicated the agency would initiate and maintain an individual and accurate medical record for each patient receiving care. 2. A policy titled "Initial Assessments / Comprehensive Assessments", revised 4/2023, indicated if a patient requested to delay the start of care date, the clinician would contact the physician, request a change in start of care date, and document this change in the medical record. 3. A policy titled "Nursing Services", revised 2/2021, indicated the registered nurse would prepare clinical and progress notes. 4. Observation of a home visit on 1/18/2024, beginning at 9:32 AM, RN (Registered Nurse) 1 failed to assess Patient #1's breath sounds (using a stethoscope on the chest and/or back to listen to the lungs), assess their peripheral pulses and edema (feeling the arms, legs, and/or feet to check pulses and swelling), and failed to assess Patient's bowel sounds (listening to the	N0544		

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N0544	Continued from page 9 abdomen with a stethoscope). A review of the skilled nurse visit note dated 01/18/2024 at 9:32 AM, documented by RN 1 indicated Patient #1 had clear lung sounds and 1+ pitting edema (swelling that when pressed, creates a temporary indentation in the skin) to the left foot, and normal bowel sounds. During an interview on 01/18/2024 at 9:59 AM, RN 1 indicated she did not perform a full physical assessment because Patient was doing so well and would probably discharge in the next couple of weeks. During an interview on 01/22/2024 at 11:27 AM, the Clinical Supervisor indicated the nurse should document their assessment as performed at the visit. 5. A review of the start of care assessment for Patient #5, dated 12/13/2023, indicated Patient referral was received by the agency on 12/8/2023. A clinical record review failed to evidence documentation to explain the delay in the start of care. During an interview on 01/22/2024 at 2:38 PM, the Clinical Supervisor indicated she did not know why RN 1 did not complete the start of care visit within 48 hours of receiving the referral. The Clinical Supervisor indicated RN 1 should have documented communication with Patient / family and physician in a communication note. 6. During an observation of a home visit for Patient #3 on 01/22/2024, beginning at 9:00 AM, the patient showed a right chest port a cath (implanted device to access patient's veins). A review of an initial start of care assessment dated 12/04/2023 failed to evidence the port a cath in the assessment under intravenous access. During an interview on 01/22/2024, at 3:02 PM, the Administrator indicated the port a cath site should be documented by the registered nurse during the initial assessment. A review of the physician referral for Patient #3 indicated a referral for skilled nursing services for colostomy (surgical opening in the intestines) care dated 11/28/2023. A review of the initial start of care assessment was dated 12/04/2023 and failed to indicate documentation of reason for delay of start of care.	N0544		

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N0544	Continued from page 10 During an interview on 01/22/2024, at 4:00 PM, the Clinical Supervisor indicated there was not documentation as to why the start of care of the patient was delayed when the referral was dated for 11/28/2023.	N0544		
N0554	Scope of Services CFR(s): 410 IAC 17-14-1(a)(2)(B) Rule 14 Sec. 1(a) (2) (B) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (B) Prepare clinical notes. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the licensed practical nurse failed to document complete and accurate clinical notes in 1 of 1 active records with a wound (Patient #5). The findings include: 1. A policy titled “Medical Record Content”, revised 4/2023, indicated the agency would initiate and maintain an individual and accurate medical record for each patient receiving care. 2. A policy titled “Nursing Services”, revised 2/2021, indicated the LPN (licensed practical nurse) would prepare clinical and progress notes. 3. A review of the start of care assessment on 12/13/2023 by RN (registered nurse) 1 evidenced Patient #5 had 2 open surgical incisions to the abdomen and a colostomy (a surgically created opening in the abdomen for the colon). A review of LPN 1’s visit notes from 12/19/2023, 12/26/2023, 12/29/2023, 1/2/2024, 1/5/2024, 1/9/2024, and 1/16/2024 failed to evidence an assessment of the surgical wounds and the colostomy. During an interview on 1/22/2024 at 12:21 PM, LPN 1 indicated the Patient used to have wounds on the abdomen, but they had been healed for as long as she had been seeing the patient. LPN 1 indicated the patient had a colostomy which she assessed and cared for at each visit. During an interview on 1/22/2024 at 2:35 PM, the Clinical Supervisor indicated the LPN should have assessed the surgical area and document that the wound	N0554		

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(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
N0554	Continued from page 11 was healed. The Clinical Supervisor indicated the assessment of the appearance of the colostomy, presence of stool, and surrounding skin should be documented at each nurse visit.	N0554		
N0566	Scope of Services CFR(s): 410 IAC 17-14-1(c)(5) Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (5) prepare clinical notes; This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the therapist failed to prepare complete notes in 1 of 1 record reviewed receiving only therapy services (Patient #7). The findings include: A policy titled “Rehabilitation Services”, revised 2/2021 indicated the therapist would document notes which included any variable factors that influenced the patient’s condition. A transfer summary dated 10/24/2023 by PT 2 indicated Patient #7 was transferred to the hospital but failed to evidence the reason for transfer. A clinical record review failed to evidence the reason for transfer. During an interview on 1/22/2024 at 3:38 PM, the Clinical Supervisor indicated if a patient is transferred to the hospital, the clinician should document the reason for transfer.	N0566		