| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 157633 | A. BUILDING<br>B. WING | 10/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| G0000 | INITIAL COMMENTS<br><br>This visit was for a 2nd Post Condition Revisit of a Federal and State Complaint survey of a deemed Home Health Provider on 6/25/2024.<br><br>Survey Dates: 10/17/2024, 10/18/2024, and 10/22/2024<br><br>Unduplicated Skilled Admissions for the last 12 Months: 348<br><br>On 10/28/24, the administrator was notified the exit date was extended to 10/22/24 due to a phone call made during the survey, was returned on 10/22/2024.<br><br>During the 2nd Post Condition revisit survey, the Conditions of Participation at 42 CFR 484.60 Care Planning, Coordination of Services and Quality of Care and 484.58 Discharge Planning was | G0000 | | |

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| | determined to be back into compliance.<br><br>Based on the Condition-level deficiencies during the 6/25/2024 survey, Hope Home Health Care Inc. was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 6/20/2024. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating a home health aide training, skills competency and/or competency evaluation program for a period of two years beginning 6/25/2024 and continuing through 6/24/2026.<br><br>This deficiency report reflects State Findings cited in accordance with 410 IAC 17.<br><br>Acronyms used in report: Start of Care [SOC], Registered Nurse [RN], Plan of care [POC], Physical Therapy [PT], Skilled Nurse [SN].<br><br>QR: 10/23/24 A 1 | | | |
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| 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 | G0572 | Pursuant to the State Operations Manual, Chapter 2, Section 2728B, we are submitting both our objection to this tag and a Plan of correction. For the following reasons, we believe that this tag was cited improperly:<br><br>1. Patient #17 was admitted to home care on 10-2-24. The referral came from a SNF and their representative informed us that Dr. S (should be person #19) from OS clinic would be following the patient for home care services. Clinical Manager (CM) put a communication note in the EMR for the | 2024-11-19 |

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| | 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 agency failed to develop a written plan of care with the physician in 3 of 4 active clinical records reviewed (Patient #17, 18, and 19).<br><br>The findings include:<br><br>1.A review of the clinical record for Patient #17 evidenced a SOC comprehensive assessment, which indicated the visit began at 4 PM on 10/02/2024 and was completed by RN 4; the documentation indicated RN 4 provided education to Patient related to their post fall and right femur fracture, hypertension, recurrent history of urinary tract infection, anemia, and instructed Patient on their medications.<br><br>The record indicated a SN visit was completed by RN 4 on 10/10/2024 which indicated RN 4 completed a head-to-toe assessment and provided Patient education.<br><br>The record included a PT visit note dated 10/15/2024; the | | admitting clinician, RN4, that Dr. S would be giving orders. RN4 called OS clinic to speak with Dr. S or his representative while at patient #17 home. Patient then told RN4 that she was not going to follow up with Dr. S but that she was going to follow up with NP V (should be person 18). RN 4 confirmed with medical assistant J at OS Clinic the NP V would give orders and an appointment was made for patient to follow up with NP V at the same time. Person 19 and Person 18 identified by surveyors was not correct.<br><br>Agency disputes surveyor's documentation that RN4 told her she had not spoken with anyone at OS clinic. RN4 also has a communication note about the conversation as well as an order indicating SN frequency and when PT was to evaluate the patient. That information was in the EMR at the time of survey and will be submitted as supporting documentation.<br><br>Agency is unsure who Person 26 (NP at Entity 21) is. There were only two practitioners from OS Clinic that RN4 was aware of for giving orders. This information was added to our Statement of deficiencies after the surveyors exited on 10-18-24. This information was not shared with Agency and on 10-28-24 Bridget from IDOH called Agency to inform us our exit date was changed from 10-18-24 to 10-22-24 because of this phone call, but would not say who it was or what it was about.<br><br>Although the time on the physician order was incorrect, the order WAS correct and the agency did obtain orders for continued care.<br><br>There was a lot of confusion on who was going to give orders for this patient. Clinical Manager will make sure that we have the name of the correct physician or NP who will be giving orders for patients when they discharge from a SNF. Clinical Manager will be responsible for making sure we have the correct following practitioner and also educate clinicians that if the practitioner is not correct in the EMR to | |

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| | note indicated PT 4 completed an initial assessment and provided Patient with strengthening exercises and gait training.<br><br>An agency document titled "Physician Order" dated 10/02/2024, written and signed by RN 4 at 7:37 AM, indicated she received an order for Patients skilled services to be provided, from Person 18 (physician), to included SN and PT.<br><br>A communication note, signed by the Clinical Manager and dated 10/2/2024, indicated Person 19 (nurse practitioner) would provide the orders for the home health services to be provided.<br><br>A POC for the initial certification period 10/2/2024 -11/30/2024 indicated Person 19 was the attending practitioner, responsible for the POC; the record failed to evidence Person 19, or their authorized agent, authorized Patients POC nor interim verbal orders for the skilled services provided through 10/17/2024.<br><br>On 10/17/2024, at 4:44 PM, RN 4 indicated she had not spoken | | contact the CM immediately with the name of the correct practitioner and who they obtained orders from. Clinical Manager will be responsible for the ongoing monitoring of this deficiency.<br><br>2. Patient #18 was admitted on 10-10-24. Agency disputes the surveyor's statement that there was no evidence of interim orders or a Plan of Care. There was an order for services on 10-10-24. Plan of care was sent to the physician on 10-18-24. RN1 states she never spoke with surveyor about this patient. She states that surveyor called her and left message to call back. She called survyor back on 10-18-24 but survyor told her she could not speak with her then. Surveyor called her back later but she was already at another patient's home and could not take call. RN1 states she spoke with Diane at Dr Benchik's office who is Dr Benchik's representative on 10-10-24 while sitting outside patient's home and Diane told her Dr Benchik approved the order.<br><br>3. Patient #19 was admitted on 10-11-24. The surgeon always sends the same standing orders for all his surgical patients. Most of the orders are dependent on the patient's status after surgery such as if they are on Coumadin (an anti-coagulant) and if they are sent home with other DME such as an ice machine, CPM machine, or RoTech bike. The Plan of care did not include that PT/INRs were to be done as patient was not on Coumadin. Patient was only on Aspirin 81 mg twice daily. The order was for the SN to go twice on 10-11-24 as patient had excessive drainage from her surgical incision that was reported by the PT who saw her after RN4 admitted her. The SN was to go starting week of 10-13-24: 2w1; 1W1 and PT wa to go 1W1; 3W1; 2W1. Surveyor's report that PT was to go 2W2 then 2W1 and that SN was to go 1W3 was incorrect.<br><br>The Plans of Care were in the Agency's EMR which the surveyor could have looked at when she was here. The Plan of Care could not be printed out immediately when she asked for it 20 minutes after she entered the building | |

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| | to or received a return phone call confirming the home health POC nor verbal orders from either Person 18 or Person 19 for the skilled services to be provided.<br><br>On 10/18/2024, at 9:47 AM, RN 4 confirmed she did not speak with neither Person 18 or Person 19.<br><br>On 10/22/2024, at 2:10 PM, the medical assistant for Person 26 (nurse practitioner at Entity 21) indicated Person 19 did not give orders for home health for Patient nor had Person 19 seen Patient and indicated Patient was seen by Person 26 (nurse practitioner).<br><br>2. The clinical record for Patient #18 was reviewed on 10/17/2024 at 1 PM; the record indicated a SOC of 10/10/2024, evidenced the initial comprehensive assessment was completed by RN 1 on 10/10/2024. The record included an unsigned SN visit was completed on 10/16/2024, which indicated the nurse completed a head-to-toe comprehensive assessment and provided patient education.<br><br>The clinical record failed to | | because we are required to have OASIS completed and coded properly as well as sixteen (16) other items and then after the clinician signs the OASIS assessment, the Plans of Care can then be printed. All Plans of Care were printed and given to the surveyor before she exited on 10-18-24. Patient #19 that she requested a written Plan of Care for was only day 5 after SOC. Patient #16 that she requested was only day 6 after SOC. Both were post surgical patients and both had orders from the surgeon. The admitting nurse had spoken with the surgeon about both and had received orders for the plan of care which was being processed on October 17, 2024. Surveyor was given the written plan of care for both before she exited and the plan of care was given to each patient before she exited the agency.<br><br>Clinical Manager has educated all clinicians on the need to complete OASIS and Plans of Care in a timely manner so they can be coded and reviewed for accuracy. All clinicians will continue to consult with physician or allowed practitioner to develop and approve of the plan of care. | |

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| | evidence interim physician orders, nor a POC, by the attending or an authorized surrogate, to include the disciplines to provide skilled care and the care to be provided, the frequency of skilled clinician visits, interventions, and patient goals, at time of review.<br><br>On 10/17/2024, at 4:21 PM, RN 1 indicated she spoke to a representative for Person 23, did not speak to the physician nor an authorized agent, nor did she receive a return phone call from the physician's office approving / confirming skilled care orders for care.<br><br>3. A clinical record review for Patient #19, SOC 10/11/2024, included post-surgical standing orders dated 9/18/24, which indicated physical therapy to provide services 3 times a week for 2 weeks and skilled nursing to obtain PT/INRs on Monday and Thursday.<br><br>The clinical record failed to evidence a plan of care, until requested by surveyor on 10/17/2024, which is 6 days after the start of care. The plan | | | |

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| | therapy to be provided 2 times a week for 2 weeks then 2 time a week for 1 week and skilled nursing 1 time a week for 3 weeks. The plan of care failed to include skilled nursing to obtain PT/INR orders. The clinical record failed to evidence a skilled nursing visit on 10/14/2024 (Monday). The clinical record failed to evidence a revised interim written verbal orders for the changed of discipline frequencies and if the PT/INR was discontinued.<br><br>On 10/17/2024, at 2:40 PM, the Clinical Manger indicated the POC could not be generated because the assessing nurse did not sign the initial comprehensive assessment.<br><br>4. On 10/17/2024, beginning at 12:14 PM, the Clinical Manager indicated there were no other written plans of care developed for their patients, in the interim, while the agency waited for their QA to review each patients' comprehensive assessment; the clinical manager indicated the POC may not be generated until the initial comprehensive assessment is through the final | | | |

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| | assessing clinician. The Clinical Manager indicated Person 1 was the attending physician for Patients #16 and #19, and the physician's referral included standing post-operative orders for joint replacements that were not patient-specific but general orders.<br><br>410 IAC 17-13-1(a) | | | |
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| G0590 | Promptly alert relevant physician of changes<br><br>484.60(c)(1) | G0590 | Pursuant to the State Operations Manual, Chapter 2, Section 2728B, we are | 2024-11-25 |

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| | The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.<br><br>Based on record review and interview, the agency failed to notify the physician of changes in the patient's condition that suggest the plan of care should be altered in 1 of 3 active clinical records reviewed with physical therapy (PT) services. (Patients # 17)<br><br>The findings include:<br><br>A review of the clinical record for Patient #17, indicated a SOC of 10/2/2024; a SN visit note, completed by RN 4 and dated 10/10/2024, indicated Patient felt depressed and expressed not wanting to live alone due to feelings of loneliness.<br><br>The initial comprehensive assessment, dated 10/02/2024, included documentation that during Patients' visit to their nurse practitioner [NP] on 10/01/2024, the NP discontinued Patients' antidepressant.<br><br>The clinical record failed to evidence the agency notified the physician of Patient's feelings of depression and | | submitting both our objection to this tag and a Plan of correction. For the following reasons, we believe that this tag was cited improperly:<br><br>Patient #17 was seen by RN4 on 10-10-24. Surveyor's reportthat patient saw NP on 10-1-24 was incorrect. Patient was admitted on 10-2-24from Ignite Medical Resort and saw NP on 10-9-24. From RN4 note on 10-10-24which was available for surveyor to read on 10-17-24, "Sn for skilledassessment and teaching s/p fall and right hip fracture as well ashypertension, recurrent hx of utis, copd, and anemia. Patient pleasant sittingon rollator. Instructed patient regarding all medications ordered by md and howto take each. Patient states had a follow up appt with NP at Oakstreet healthyesterday who ordered trazodone discontinued and not taking now . Patientinstructed on pain management of right leg and use of tylenol for pain whichpatient states relieves pain. Instructed patient on fall risks and precautionsand care when goes into yard of patients sons dog- keep out of pathway toprevent falls. Instructed | |

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| | loneliness, since antidepressant medication was discontinued.<br><br>On 10/18/2024, at 2:34 PM, RN 4 indicated she had not notified the physician of Patient's report of depression and loneliness.<br><br>410 IAC 17-13-1(a)(2) | | patient on using rollator at all times. Patientinstructed on need for PT to perform evaluation, patient states "IVe beenbusy with appts and regrouping here at home . He can come next week. **Coordinationof care with PT and NP regarding delay in service**. Patient also states hasa cell phone to call directly to schedule visits. Number given and given tooffice for primary contact as well as PT. Phone number noted on chart. Patientfollowed up with NP yesterday at Oak Street who dced patients trazodone ,patient states due to NP concerned that it may cause loss of balance and causea fall as well as may cause patient to become dizzy . Instructed patient on allmedications. Patient requests not wanting to live in home by self anymore dueto feels lonely by self even though son is next door and feels wound be safer.Patient requesting information regarding 55 and older facilities near Hammond.List of facilities in local area given to patient to call and follow up on thisweek. Offered to contact NP for sw referral however patient refuses stating" this information is all I need ". | |

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| G0606 | Integrate all services<br><br>484.60(d)(3)<br><br>Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines.<br><br>Based on record review and interview, the agency failed to coordinate care with all disciplines and agencies providing care to the patient in 2 of 4 active clinical records reviewed (Patient #17 and 18).<br><br>The findings include:<br><br>1. On 10/18/2024, at 12:55 PM, PT 4 indicated Patient #17 was in the middle of selling their house, was anxious about where they would live, indicated they did not feel safe. PT 4 indicated he did not notify the nurse case manager of Patient's feelings of being unsafe.<br><br>A review of the clinical record failed to evidence PT 4 coordinated care with the nurse case manager regarding Patient expression they did not feel safe.<br><br>On 10/18/2024, at 2:34 PM, RN 4 indicated PT 4 had not | G0606 | Pursuant to the State Operations Manual, Chapter 2, Section 2728B, we are submitting both our objection to this tag and a Plan of correction. For the following reasons, we believe that this tag was cited improperly:<br><br>1. PT4 had evaluated Patient #17 on 10-15-24 which was 2 days prior to surveyor beginning this survey. Surveyor brought up this therapist's comment during the exit conference. After the exit conference, Clinical Manager called therapist about his comments. Therapist stated that he did not mean that patient did not feel "safe." Therapist stated that she was moving because she said her neighborhood was not very safe anymore. This is the same patient that RN4 gave information to about 55 and over living communities. RN4 clearly stated on her 10-10-24 note about the living situation and that patient was going to be moving. Therapist stated that surveyor called him to find out about how he was able to get a hold of patient as she was trying to reach patient. That is when he told her that patient was in the process of moving because she didn't feel safe in the neighborhood anymore. Both PT4 and RN4 knew patient was moving because of the neighborhood.<br><br>2. Patient #18 was admitted on 10-10-24. Coordination of care was done on 10-17-24 which is when this agency was able to find out the name of the other agency providing care for this patient. Form was uploaded on 10-17-24 to reflect the name of the other agency as well as the days and times someone was going and what services they were providing. Agency disputes that this standard was not met. Rebekah even asked Alternate DON, who had done the coordination of care with the other agency, if that was all she had. Alt DON replied yes. Supporting documentation to what was given to surveyor is attached.<br><br>Clinical Manager has educated all clinicians to get the name of any other agencies providing care for patients upon admission or as soon as | 2024-11-22 |

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| | communicated with her about Patient's feelings of being unsafe.<br><br>2. A review of the Patient #18's clinical record, on 10/17/2024, included an initial comprehensive assessment, dated 10/10/2024; the assessment indicated Patient resided with the spouse, who worked Monday through Friday and Patient received care from an unknown outside source, a few hours per day, while their spouse was at work. The clinical record failed to evidence coordination of care with the outside source, with the type and frequency of services and care provided.<br><br>On 10/18/2024, at 1:32 PM, Patient's spouse indicated Patient had caregiver services, through Entity 24, from 5 PM to 10 PM Monday through Friday while they were at work; they indicated their work schedule was 2 PM to 10 PM.<br><br>A care plan obtained from Entity 24 indicated Entity 24 provided non-skilled respite care from 5 PM to 10 PM Monday through Friday.<br><br>On 10/18/2024, at 2:05 PM, | | information to us. Coordination of care will continue to be done with other agencies as well as all staff seeing patients to make sure services are integrated to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. | |

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| | Person 25 at Entity 24 indicated Entity 24 provided Patient non-skilled homemaker and attendant care from 5 PM to 10 PM Monday through Friday.<br><br>On 10/18/2024, at 3:17 PM, the Clinical Manager indicated the agency did not coordinate care with Entity 24 until 10/17/2024.<br><br>410 IAC 17-12-2(g), 410 IAC 17-12-2(h) | | | |
| N0000 | Initial Comments<br>This visit was for a 2nd revisit for a State re-licensure and Complaint Survey of a Home Health Provider.<br>Survey dates: 10/17/2024, 10/18/2024, and 10/22/2024<br>12-Month Unduplicated Skilled Admissions: 348 | N0000 | | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Kim Krull | RN<br>Administrator/Clinical | 11/27/2024 1:18:31 PM |