STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157608	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER HOMECARE SERVICES LLC	614 EAST 53RD STREET , ANDERSON, Indiana, 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
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 for a Home Health Provider and Suppliers. Survey Dates: August 12, 13, 14, and 15, 2024 Census: 211 At this Emergency Preparedness survey, Hoosier Homecare Services was found to be in compliance with Conditions of Participation 42 CFR 484.102 Emergency Preparedness requirements for Medicare Participating Providers and Suppliers.	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: August 12, 13, 14, and 15, 2024 12-Month Unduplicated Skilled Admissions: 720 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. QR 8/23/24 A2	G0000		
G0536	A review of all current medications CFR(s): 484.55(c)(5) 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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure medications were reviewed as part of the comprehensive assessment for 2 of 7 patient	G0536		

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

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G0536	Continued from page 1 records reviewed with a home observation visit (Patient #3 and #4). Findings include: 1. The comprehensive patient assessment policy indicated “The Comprehensive Assessment will include a review of all medications the patient is using.” 2. The medication profile policy indicated “To provide documentation of the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile.” 3. Review of Patient #3’s clinical record indicated a start of care of 5/23/24 and included a comprehensive assessment performed by PT 2 on 7/17/24. The clinical record also included a medication list. The medication list included Amlodipine Besylate (a medication used to treat high blood pressure) 5 milligrams (mg) to be taken by mouth once daily and also included Norvasc (brand name for Amlodipine Besylate) to be taken by mouth once daily. The clinician failed to ensure the medication list did not contain duplicate medications. During an interview on 8/15/24 at 1:47 PM, PT 2 indicated he guessed that one of the medications must have stayed in the patient’s medication profile from a previous entry and had not been deleted. 4. Review of Patient #4’s clinical record indicated a start of care of 4/8/24 and included a comprehensive assessment performed by PT 2 on 8/01/24. The clinical record also included a medication list. The medication list included Lomotil (a medication used to treat diarrhea) 2.5-0.25 mg to be taken by mouth 4 times per day as needed, Tums gas relief chewy bites (a medication used to relieve heartburn, indigestion, and upset stomach) oral 750-80 mg to be taken by mouth as needed 3-4 times per day for indigestion, Miralax (a medication used to treat constipation) 17 grams to be taken 1 packet by mouth once per day, Amlodipine Besylate 5 mg to be taken by mouth once per day, and Triamcinolone Acetonide External 0.1% (a topical medication used to treat a variety of skin conditions) to be applied topically twice daily. During a home visit observation of PTA 1 providing care to Patient #4, Patient #4 and their caregiver indicated Patient #4 no longer had Lomotil, Tums, Miralax, Amlodipine Besylate, or Triamcinolone Acetonide in the home as it had been at least one year since the patient had used those medications. PT 2 failed to perform an	G0536		

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G0536	Continued from page 2 accurate comprehensive assessment of Patient #4's medications. During an interview on 8/15/24 beginning at 1:47 PM, PT 2 indicated he looked at Patient #4's pill bottles at start of care but wasn't sure if he looked at them at the recertification assessment. PT 2 indicated he did not know why the Lomotil, Tums, Miralax, amlodipine, and triamcinolone were on the medication list when the patient and caregiver had indicated the patient had not taken these in at least a year. 410 IAC 17-14-1(a)(1)(B)	G0536		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge;	G0574		

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G0574	Continued from page 3 (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the plan of care (POC) included all medical equipment for 1 of 4 active records reviewed receiving physical therapy (PT) service with no home visit observation (Patient #11). Findings include: 1. Review of the clinical record of Patient #11 included a PT Evaluation completed on 06/21/2024 by PT 1 that indicated an overhead trapeze was used (medical equipment used to assist with moving, raising and lowering the body while in bed) to assist with bed mobility. Review of the POC for Patient #11 for certification period 06/21/2024 – 08/19/2024 failed to evidence orders for an overhead trapeze. During an interview on 08/14/2024 at 12:37 PM, when asked what durable medical equipment was used by Patient #11, PT 1 indicated a wheelchair, shower chair, safety bars, hospital bed, and overhead trapeze. 410 IAC 17-13-1(a)(1)(c)(ii)	G0574		
G0714	Patient and caregiver education CFR(s): 484.75(b)(5) Patient and caregiver education; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the skilled nurse failed to provide the patient with individualized education for 1 of 5 active records reviewed with no home visit observation (Patient #11). Findings include: 1. Review of the clinical record of Patient #11 with	G0714		

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G0714	Continued from page 4 start of care date, 09/10/2020, included diagnoses, but were not limited to, cystostomy (surgical opening into the bladder through the abdominal wall to allow urine to drain) and hereditary spastic paraplegia (disorder that causes progressive weakness and stiffness in leg muscles). Review of documentation completed by licensed practical nurse (LPN) 1 on 04/25/2024, 05/22/2024, and 07/18/2024 included patient education provided by LPN 1 that included emptying bladder entirely each time urinating and to refrain from holding urine. The agency failed to ensure individualized education was given to the Patient. During an interview on 08/14/2024 at 12:46 PM, when asked how Patient #11 eliminated urine, LPN 1 indicated Patient #11 was unable to urinate due to paralysis, unable to hold urine, and urine was eliminated through a suprapubic catheter (a hollow tube used to drain urine from the bladder through a cut in the abdomen) 410 IAC 17-14-1(a)(2)(E)	G0714		