STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003788	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HOMECARE NETWORK	1107 S TILLOTSON AVE, SUITE 1 MUNCIE, IN 47304

(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) COMPLETE DATE
N 000	Initial Comments This was state complaint survey to investigate 3 (three) complaints. IN00335327; Substantiated IN00334792; Substantiated IN00332908; Substantiated Survey Dates: August 10, 11, 12; 2021 Facility Number: 003788 Skilled: 137 Total Active Census: 137 Unduplicated Admissions for previous 12 months: 607	N 000		
N 470	410 IAC 17-12-1(m) Home health agency administration/management 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 RULE is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure COVID-19 infection control precautions were followed for 2 of 2 patient home visit observations (#3, 4). Findings include: 1. A policy titled "Exposure to Coronavirus [COVID-19]: Disease Response & Management," stated " ...Patients should be assessed prior to each visit for exposure associated with risk of COVID-19 infections [e.g., travel to geographically affected areas, close contact with confirmed cases or persons under suspicion for	N 470		

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N 470	Continued From page 1 COVID-19, or contact with family members/friends who have traveled to geographically affected areas] ...." 2. The clinical record of patient #3 was reviewed on 8/11/21 at 10:10 AM, and indicated a start of care date of 7/14/21. The record contained a plan of care for the certification dates 7/25/21 to 9/11/21. During a home visit on 8/11/21 at 1:00 PM with patient #3, Registered Nurse I was observed screening patient for COVID symptoms after already having physical contact with the patient. 3. The clinical record of patient #4 was reviewed on 8/11/21 at 11:00 AM, and indicated a start of care date of 6/27/21. The record contained a plan of care for the certification dates 6/27/21 to 8/25/21. During a home visit on 8/11/21 at 2:30 PM with patient #4, Registered Nurse J was observed screening patient for COVID symptoms after already having physical contact with the patient. 4. During an interview on 8/12/21 at 11:30 AM, when asked if staff needed to screen for COVID symptoms before having physical contact with the patients, the Administrator stated, "Yes".	N 470		
N 514	410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following:	N 514		

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N 514	Continued From page 2 (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to thoroughly investigate and document complaints for 5 of 5 complaints reviewed. Findings include: 1. A policy titled "Grievance Procedure, Patient Complaints," stated " ...After the investigation and analysis is completed, but no later than 30 [thirty] days after the complaint/grievance filing, the Executive Director or Clinical Director will follow-up with the patient and/or complainant and document within the information system ...." 2. A document titled "Patient Rights and Responsibilities," stated " ...The patient has the following rights ... voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so ...." 3. An agency complaint reviewed from the complaint log dated 8/11/20 , regarding Patient #1, indicated "...Description ... patient upset that RN [registered nurse] who did his visit on Friday failed to inform him of dose changes to warfarin ... patient requests that RN not return to him ... Interventions ... apologized and offered another	N 514		

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N 514	Continued From page 3 caregiver ... apologized for failed expectations ... apologized for inadequate communication ... notified RN of complaint ... ED [executive director] reviewed complaint w/ [sic] employee involved ... notified risk management of complaint ... PCM [patient care manager] made call to MD [medical doctor] for orders ... spoke with complainant to resolve issues .... Prevention ... scheduler will assign different clinician ... education provided to staff ... reviewed call number with patient to call on call ... reviewed complete care management with staff ... reviewed complaint with physician ...." The complaint failed to evidence a thorough complaint description and complaint investigation evidenced by missing staff interviews and no other patients with same staff who cared for them were interviewed to see if systemic problems existed. 4. An agency complaint reviewed from the complaint log dated 8/18/20 indicated "...Description ... Patient stated [sic] [Registered Nurse E] did not wash/cleanse wound on Saturday ... only added new foam and tape to wound vac ... Interventions ... Notified RN [registered nurse] of complaint ... SN [skilled nurse] instructed on cg [caregiver] calling office and number ... provide education to staff member ... Prevention ... apologize/reassure patient ed [education] would be provided ... reviewed call number with patient to call on call ... Follow-up comments ... education session with [Registered Nurse E] regarding wound care policy and expectations of compliance with policies and plan of care/orders ...." The complaint failed to evidence a thorough complaint description and complaint investigation evidenced by missing staff interviews and no other patients with same staff who cared for them were interviewed to see if systemic problems existed.	N 514		

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N 514	Continued From page 4 5. An agency complaint reviewed from the complaint log dated 8/22/20 indicated "...Description ... Patient states that he gave his order for labs to [Registered Nurse E] on her last visit ... Patient upset related to the fact that no orders have been entered and he does not have his prescription that has his lap [lab] orders on it ... Interventions ... notified director ... notified executive director ... Intervention/Resolution comments ... Skilled nurse notified via email ... [Registered Nurse E] was notified and stated that patient did not give her a lab order/prescription as the complaint states ... Prevention ... skilled nurse apologize [sic] to patient ... Follow-up comments ... [Registered Nurse E] was contacted by director and asked regarding lab order ... [Registered Nurse E] states that patient did not present her with a prescription/order for lab work at start of care visit ... [Registered Nurse E] was going to follow up with patient and with the MD [medical doctor] regarding the labs ...." The complaint failed to evidence a thorough complaint description and complaint investigation evidenced by missing staff interviews and no other patients with same staff who cared for them were interviewed to see if systemic problems existed. 6. An agency complaint reviewed from the complaint log dated 12/14/20 indicated "...Description ... [Physician A] called IHC office stating patient had a scheduled f/u [follow up] visit on 12/11 [2020] ... MD [medical doctor] states patient arrived for his appointment with a frozen shoulder ... He was very upset stating the patient had just been discharged from home health services five days prior with goals met ... Interventions ... ED [Executive Director] notified RVP [regional vice president] ... ED discussed	N 514		

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N 514	Continued From page 5 with Clinician ... ED reviewed complaint w/ [sic] employee involved ... Documentation review ... Interviewed clinicians involved in patient's care ... Intervention/Resolution comments ... Quality and risk management aware ... Collaboration complete ... Education given to clinician regarding expectation with case management ... Prevention ... reviewed quality visit/expectations with clinician ... Prevention Comments ... review expectation with clinicians of need for and importance of documentation of communication with CM [case manager] regarding patient progress or lack thereof and D/C [discharge] plan ... review expectation that clinician contact MD, and document notification, R/T [related to] patient's lack of progress ... Follow-up comments ... PCM [patient case manager] and ED follow up with MD ... MD appreciated call backs and stated he may write orders to have IHC [Indiana Home Care] back in for further therapy to work with patient ...." The complaint failed to evidence a thorough complaint description and complaint investigation evidenced by missing staff interviews and no other patients with same staff who cared for them were interviewed to see if systemic problems existed. 7. An agency complaint reviewed from the complaint log dated 6/21/21 indicated "...Description ... [Speech Therapist F] went to complete an ST [speech therapy] visit for the patient with [Registered Nurse D] from Muncie office ... She felt the visit went well ... she interacted with the patient as she typically does ... talking, laughing, exercises, breaks in between ... I had minimal contact with [Registered Nurse D] ... however, I did speak wither about medications and patients poc [plan of care], etc ... Upon calling patient's daughter on the evening of May 19 to schedule my next appointment she	N 514		

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N 514	Continued From page 6 reported to me that the patient becomes very paranoid with laughing around her ... she stated that my last visit must have really upset her because the following day my last visit she was noticeably upset ... I apologized and thanked her for bringing it to my attention ... Follow-up comments ... ED [executive director] notified of complaint and will follow up with clinician, patient, and caregiver ... ED discussed situation with clinician as well as [Registered Nurse D] since she was present as soon as complaint received per [Speech Therapist F] ... called patient's daughter ... no further complaints voiced ... she shared that her mother does get paranoid when others are talking or laughing and she's not involved in the conversation ... she states she feels the situation was addressed appropriately and that there is no need for further follow up ... states she is pleased with our services ...." The complaint failed to evidence a thorough complaint description and complaint investigation evidenced by missing staff interviews and no other patients with same staff who cared for them were interviewed to see if systemic problems existed. 8. An agency complaint reviewed from the complaint log dated 6/21/21 indicated "...Description ... Patient's POA [power of attorney] left voicemail wanting a change in clinician due to patient not having a satisfactory experience with [Registered Nurse G] ... POA states that she encouraged patient to accept [Registered Nurse G] but could not get along with her ... States she is bossy and by-the-book [sic] ... POA states that [Registered Nurse G] has been very helpful, but her son and use to his schedule [sic] and [Registered Nurse G] does not want to follow that ... [Registered Nurse G] compares him to her daughter which makes him upset ... Follow-up/Monitoring ... ED [executive	N 514		

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N 514	Continued From page 7 director] notified of complaint, followed up with patient POA, Patient reassigned to another clinician ... will follow up with POA, in [sic] satisfaction of care once reassignment complete ... Reassignment successful with new RN [registered nurse] ... no further complaints voiced per POA ...." The complaint failed to evidence a thorough complaint description and complaint investigation evidenced by missing staff interviews and no other patients with same staff who cared for them were interviewed to see if systemic problems existed. 9. During an interview on 8/12/21 at 11:30 AM, when asked if complaints needed to be thoroughly investigated to see if the problem is a systemic issue, the Administrator stated, "Yes". 17-12-3(c)(1)(A)	N 514		
N 524	410 IAC 17-13-1(a)(1) Patient Care 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. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments.	N 524		

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N 524	Continued From page 8 (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 RULE is not met as evidenced by: Based on record review and interview, the home health agency (HHA) failed to ensure the medical plan of care contained all accurate medications the patient was taking for 1 of 2 records reviewed with home visit observations (#4). Findings include: 1. A policy titled "Monitoring Medications," stated " ...All clinicians participating in the patient's care are responsible to assist with the maintenance of accurate medication information throughout the episode of care ... During the patient's episode of cares episode of care the following will occur ... the care team will ... compare medications patient is currently taking with medications ordered for the patient in order to identify and resolve discrepancies ...." 2. The clinical record of patient #4 was reviewed on 8/11/21 at 11:00 AM, and indicated a start of care date of 6/27/21. The record contained a plan of care for the certification dates 6/27/21 to 8/25/21, that indicated diagnoses of, but not limited to, urinary retention (Inability to voluntarily empty the bladder completely or partially), atrial fibrillation (irregular heart rhythm), and benign prostatic hyperplasia (condition in which the flow of urine is blocked due to the enlargement of prostate gland). The record included a document	N 524		

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N 524	Continued From page 9 titled, "Medicine List", indicated orders for, but not limited to, " ... Atorvastatin 20 [twenty] mg [milligram] oral 1 [one] tablet daily [treats high cholesterol and triglycerides] ... Carvedilol 3.125 mg [milligram] oral 1 [one] tablet 2 [two] times daily [treats high blood pressure and heart failure] ... Lisinopril 5 [five] mg [milligram] oral 1 [one] tablet daily [treats high blood pressure] ...." During a home visit on 8/11/21 at 2:30 PM with patient #4, the patient stated he was "taking the meds in the basket." Upon inspection, the medications included Atorvastatin 10 mg, Carvedilol 6.25 mg, and lisinopril10 mg. 3. During an interview on 8/12/21 at 11:30 AM, when asked if all medications needed to be current and accurate, the Administrator stated, "Yes".	N 524		
N 539	410 IAC 17-14-1(a)(1) Scope of Services Rule 14 Sec. 1(a)(1) The registered nurse shall perform nursing duties in accordance with the Indiana Nurse Practice Act (IC 25-23). This RULE is not met as evidenced by: Based on observation, record review and interview, the registered nurse failed to complete a nursing assessment per professional standards for 1 of 2 nursing home visits observed (#3). Findings include: The clinical record of patient #3 was reviewed on 8/12/21 at 10:30 AM and indicated a start of care date of 7/14/21. The record contained a plan of care for the certification dates of 7/14/21 to 9/11/21, that indicated diagnoses of, but not	N 539		

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N 539	Continued From page 10 limited to, essential hypertension (high blood pressure), open wound of the right great toe without damage to the nail, and osteomyelitis (bone infection). During a home visit on 8/11/21 at 1:00 PM with patient #3, Registered Nurse (RN) I, completed patient's vital signs and completed wound care. RN I failed to perform a physical head to toe assessment at the visit.	N 539		