PRINTED: 06/23/2021
FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			
		157436	B. WING		04/19/2021	
	PROVIDER OR SUPPLIER		11037	ADDRESS, CITY, STATE, ZIP COD BROADWAY, SUITE C IN POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DDOVIDED'S DI AN OF CODDECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE	
G 0000						
Bldg. 00	control and compla health agency.  Complaint # IN003 findings	dederal focused infection int investigation of a home 45294 - substantiated with 42021, 4/15/2021, 4/16/2021	G 0000	Per direction above, no action required		
G 0468	accordance with 41 for additional state 484.50(d)(5)(iii)	-				
Bldg. 00	any), with contact agencies or provide provide care; and Based on record revaluation for othe would be able to propatients. (#2)  The findings included An agency policy, representation of the contact o	itient and representative (if information for other information for other information for other information information for other information informat	G 0468	What action will we take to correct the deficiency cited? EDUCATION: All field clinician transitional care coordinators a Clinical Manager were in-servi on the Indiana state 15-day notification of discharge policy Staff was also educated on the proper coordination of alternat services, in the event a transitiplan is needed. POLICY UPDATE: Agency Po and Procedure manual has be updated as of April 19th to incithe 15-day discharge notificati	ns, and iced  /. e tive ion  plicy een lude	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2IZE11 Facility ID: IN008882 If continuation sheet Page 1 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/19/2021 157436 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11037 BROADWAY, SUITE C HRS HOME HEALTH OF INDIANA, LLC CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE given to the adequacy and suitability of PATIENT INFORMATION organization personnel, resources to provide the PACKET: Discharge policy and required services, and the reasonable expectation procedure was updated and added that the patient's medical, nursing, rehabilitative, within the Patient Bill of Rights. and social needs can be adequately met in the DOCUMENTATION: In the event a patient's place of residence ... A patient will be patient's care exceeds what can transferred to other resources if the organization be provided, communication to the cannot meet his/her needs ... Once a patient is MD and patient of the looming admitted to service, the organization is discharge will be documented in responsible for providing care and services within the chart. To ensure no lapse in its financial and service capabilities, mission, and care to the patient, the agency will applicable law and regulations. work with the patient's MD to determine a transition plan (i.e. Review of the agency's admission packet, another home health agency, evidenced on page 12, "HRS HOME HEALTH skilled nursing facility, etc.) that DISCHARGE CRITERIA" which stated "1. best suits the patient's/family's Services will be terminated when the patient meets needs and wishes. Care will one or more of the discharge criteria: A. A change continue until the transition is in the patient's medical or treatment program that complete. requires a change to a different level of care. B. A change in the patient's condition requires care or Who is responsible to services other than that provided by the implement the corrective organization. If the patient's acuity requires action? another level of care that the organization cannot Administrator provide, the organization shall arrange for a safe and appropriate transfer to another organization What is the monitoring process that can provide the needed level of care ... D. we will put into place to ensure The patient or family/ caregiver refuses, implementation and discontinues care, or elects to transfer to another effectiveness of this corrective organization. E. The patient or family/ caregiver action plan? refuses to cooperate in attaining the objectives of All cases requiring a transition homecare... G. The patient and/or family display plan will be discussed amongst disruptive abusive an uncooperative behavior ... the Administrator, Clinical PROCEDURE ... 5. The decision to terminate or Manager, physician, and patient reduce services must be documented in the prior to the transition taking place. clinical records citing circumstances in This communication will be notification to the patient, the responsible family/ documented in the patient's chart caregiver or representative, and the patient's and include the contact position. Efforts to resolve problems prior to information for the identified discharge will also be documented in the patients services.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 2 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 04/19/2021 157436 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11037 BROADWAY, SUITE C HRS HOME HEALTH OF INDIANA, LLC CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE record. The patient will be provided contact Administrator will inspect 100% of information for other home health agencies and patient discharges for the first two providers if continued care is needed. The clinical weeks after the corrective action implementation to ensure contact supervisor or designee is accountable for the decision and the required documentation. If the information was provided during decision to terminate services is due to the the transition planning patient's behavior, the behavior of other persons conversations for alternative in the home, or situation, the clinical record must service options. These cases will be discussed reflect the following: A. identification of the problems encountered ... B. Assessment of the during quarterly QAPI meetings to situation ... C. Communication with the confirm compliance. If 100% organization management and the physician compliance was achieved during responsible for the plan of care ... D. A plan to the initial two-week inspection, the resolve the issues ... E. Results of the plan discharge audit will drop to 50% of implementation ...." discharged patients within the following two-week timeline. If Clinical Record Review on 4/16/2021, for patient compliance has been met for #2, start of care 8/12/2020, diagnoses include, but these two criteria, Administrator are not limited to, multiple sclerosis (a disease in will maintain a monthly patient which nerve damage disrupts communication review of 10% of the agency's between the brain and the body), an indwelling discharged patients. urethral catheter, and history of a recent urinary In the event information was not tract infection, evidenced an agency document provided and/or not documented titled, "Home Health Certification and Plan of during an audit, the Administrator Care" for certification period of 12/10/2020 will reach out to the patient and 2/7/2021. This document had an area subtitled MD to ensure their transition plan "Orders of Discipline and Treatments" which was successful and document this stated, "Skilled nurse to assess evaluate communication. Additionally, co-morbid conditions including hypotension, re-education will take place with hypothyroidism, and other conditions that the clinical staff and clinical present themselves during the course of this manager regarding the corrective episode to identify changes and intervene to action above. minimize complications ... Skilled nurse to perform observation/assessment of genitourinary status and intervene to minimize complications of disease process ... Skilled nurse to instruct patient/caregiver in indwelling urinary catheter management of disease process including catheter, sign and symptoms of complications, perineal care, tube and bag placement ...." This

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 3 of 30

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157436	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/19/2021
	PROVIDER OR SUPPLIER		11037 E	ADDRESS, CITY, STATE, ZIP COD BROADWAY, SUITE C N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	on 12/18/2020.	ed by the patient's physician enced an agency document			
	titled "Client Coord had an that stated "I The document state called [Person C, painquire about Foley [patient] has coude tip is bent to naviga currently and upon RN was unable to, I room] for Foley pla must see urologist texchanged. [Person notified. [Person A] [patient #2] in to see	ination Note Report" which Note Type CLINICAL." d "RN [Registered Nurse] Intent #2's physician] office to catheter exchange, PT [a type of catheter where the te passed blockages] placed last attempt to place a Foley, PT went to ER [emergency cement. Per [Person C], PT to have Foley catheter A, patient #2's representative] states [they] cannot get te urologist, insisting RN do it. or's orders "This note was			
	titled "Client Coord had an that stated "I The document state 12.24.20. [Person A assess patient. After receiving an update the caregiver; I received further evan Medicine]. [Person case spoke with [Person case spoke with [Person the patient warranter needed to go to the explained the MD's [they] would not be Emergency Room a to call [Person A] b reaching patient on	enced an agency document ination Note Report" which Note Type CLINICAL." d "Spoke with [Person A] on] requested nurse for a visit to repeaking with the nurse, and on the patient's status from sommended the patient's status luation from a MD [Doctor of A] refused. The nurse on the reson C] and [they] agreed that d further assessment and Emergency Room After I recommendation [they] stated taking [Patient #2] to the nd hung up. Writer attempted ack; however, unsuccessful in second attempt " This note mer Employee B, on			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 4 of 30

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	i '		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD		00	COMPLETED	
		157436	B. WING			04/19/	2021
NAME OF F	PROVIDER OR SUPPLIER	?			DDRESS, CITY, STATE, ZIP COD		
HRS HO	ME HEALTH OF IN	DIANA, LLC			ROADWAY, SUITE C N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE
		d review failed to evidence					
		he date, time, and which					
	employee spoke to	the patient's physician.					
	Record review evid	lenced an agency document					
		lination Note Report" which					
		Note Type CLINICAL."					
		ed "RN received message from	1				
		on A] that Foley has low					
	output and bulge pr	resent to pelvic region. PT and					
	caregiver advised to	o go to ED [Emergency					
		refused. [Person C] paged. Per					
		O. CM [case manager] notified					
		contacted [Person A] to notify					
	_	son A] refused and stated "I					
		"RN received message from					
		on E, patient's family member]					
	_	ey catheter. This document					
	was entered by RN	C, on 12/26/2020.					
	Record review evid	lenced an agency document					
		lination Note Report" which					
	had an area that sta	-					
	CLINICAL." The	locument stated "DO NOT					
	RE-ADMIT: D/T [	due to] TO PATIENT					
	COMPLEXITY, N	EED OF LONG TERM CARE					
		D INVOLVEMENT, WE WILL					
		ING THIS PATIENT BACK ON					
		s note was entered on 1/14/21 by					
	the Administrator.						
	An email chain was	s submitted during clinical					
		:07 AM. The original email was					
		/2021 at 9:56 AM, which stated					
		taken to the ER to [Entity E, a					
		g food stuck in [his/her] throat	1				
		n the Administrator on					
	_	PM, stated "Team, please be					
		case we will not be accepting					
		exity and no designated care					
	1	. ~	1	l			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 5 of 30

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		157436	B. WI	NG		04/19/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			BROADWAY, SUITE C		
HRS HO	ME HEALTH OF IN	DIANA, LLC			N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		e MD [Employee E,					
		ordinator], please inform the					
		on as possible] that the					
	-	vith us but will not be					
		back. Please make sure they					
		do not DC [discharge]					
		ing he already has HH [home					
	_	because we do not want					
		abo" Record review failed to					
		eam held case conferences to ue to the increased complexity					
		rd review failed to evidence					
	*	vided with contact information					
		providers capable of handling					
		ne patient. Another response					
		n 1/20/2021, at 1:53 PM, stated					
		om [Entity E] and they					
		WAS set up with a different					
	home health. So we	-					
	nome neum 20 m	our disease of					
	Record review faile	ed to evidence what the added					
		atient entailed. Record review					
	failed to evidence the						
	family/caregiver wa	as given contact information to					
	other providers/age	ncies that would be able to					
	better serve the pati	ent.					
			1				
	-	on 4/15/2021, at 4:24 PM, the					
		ndicated the only skill the					
		ned on were ventilators					
		reath for a patient). The					
		d the agency staff was used to					
		n the hospital and are skilled					
		ses, with the exception of					
		review evidenced the patient					
	was not on a ventila	ator.					
	Duning on intermi	y on 4/15/2021 of 4:20 DM the					
		on 4/15/2021, at 4:30 PM, the					
		ated the discharge process					
	would begin during	the admission, conduct case					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2IZE11 Facility ID: IN008882

If continuation sheet Page 6 of 30

	LAN OF CORRECTION IDENTIFICATION NUMBER A.		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/19/2021	
	ROVIDER OR SUPPLIER		11037	ADDRESS, CITY, STATE, ZIP COD BROADWAY, SUITE C 'N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
G 0480 Bldg. 00	conferences through ensure the patient's inform the patient of 48 hours prior to distribute the Administrator in history of being administrator of the home of the hospital and HR resume care. Docume contact the hospital requested, but the Acould not find them the hospital requested, but the Acould not find them the hospital requested, but the Acould not find them the hospital requested, but the Acould not find them the hospital requested, but the Acould not find them the hospital requested, but the Acould not find them the hospital requested, but the Acould not find them the hospital requested, but the Acould not find them the hospital requested, but the Acould not find them the hospital of the hospital requested of the hospital o	nout the certification period, physician was aware, and representative a minimum of scharge.  To on 4/16/2021, at 11:07 AM, adicated the patient had a nitted to the hospital and with greater issues that were before. They indicated the contact the hospital case o have them find another home e patient. The Administrator t would be discharged from S Home Health would have to mentation of attempts to case manager(s) were administrator indicated they held inconsistently, or is priately; and riew and interview, the agency ent care was furnished ered on the plan of care in 1 of	G 0480	What action will we take to correct the deficiency cited? EDUCATION: All clinicians ar Clinical Manager received re-education on the on-call/after-hours triage expectations/policy.  On-call Protocol i. Weekday/Weekend/Holiday County-call RN is required to tal primary call and the Clinical Manager is secondary. ii. Triaging Cal Based on the patient's needs,	04/19/2021 ad	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 7 of 30

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMPLETED	
157436 B. WING 04/19/2021	
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER  11037 BROADWAY, SUITE C	
HRS HOME HEALTH OF INDIANA, LLC CROWN POINT, IN 46307	
PROVIDER'S PLAN OF CORRECTION	X5)
CROSS-REFERENCED TO THE APPROPRIATE	LETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DA	ГЕ
be covered by Medicare PROCEDURE 1. this be triaged over the phone v.s.	
Physician (or other authorized licensed performing a skilled visit v.s.	
independent practitioner) orders will be calling 911	
individualized, based on patient's needs, and iii. If patient's	
include: B. Treatments and/or procedures needs cannot be determined or	
needed, including type, frequency, duration, and resolved via phone, RN may	
goals" perform an on-call visit as	
appropriate and approved by  An agency policy, number 0,005, titled "Bill of	
An agency policy, number 9-005, titled "Bill of Clinical Supervisor and the Rights" revised December 2019, stated "PURPOSE patient's MD.	
Rights" revised December 2019, stated "PURPOSE patient's MD.  To encourage awareness of patient rates and	
provide guidelines to assist patients in making  Who is responsible to	
decisions regarding care Ann for active implement the corrective	
participation in planning POLICY Each action?	
patient will be an active, informed participant in  Administrator	
his/her plan of care. To ensure this process, the	
patient will be empowered with certain rights in  What is the monitoring process	
responsibilities as described PROCEDURE 2. we will put into place to ensure	
The patient Bill of Rights statement defines the implementation and	
right of the patient to: 2. B. Voice grievances effectiveness of this corrective	
regarding treatment or care that is (or fails to be)  action plan?	
furnished, or regarding the lack of respect for Clinical manager will receive daily	
property by anyone who is furnishing services on morning updates from the on-call	
behalf of the organization and must not be RN from the night prior. Clinical	
subjected to discrimination or reprisal for doing so  Manager will maintain a log of	
C. Receive an investigation by the	
organization of complaints made by the patient or from patients to ensure	
the patient's family or Guardian regarding compliance and accuracy.	
treatment or care that is (or fails to be) furnished,  Occurrences/calls will be present	
or regarding lack of respect for patients' property in the patient's chart.	
by anyone furnishing services on behalf of the In the event an occurrence was	
organization, and must document both the not properly coordinated, then all	
existence of the complaint and the resolution of clinical field staff will be	
the complaint W. The right to voice a complaint  re-educated on the On-call	
or concern regarding care or service. The Protocol and expectations.	
availability of other sources to receive questions	
and complaints and assist in resolution"	
Clinical Record Review on 4/16/2021, for patient	
Chinical Record Review on 4/10/2021, for patient	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		157436	B. W	ING		04/19/	2021
				CTDEET A	DDDECC CITY CTATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
UDC UOI	ME HEALTH OF IN	DIANA LLC			BROADWAY, SUITE C N POINT, IN 46307		
HRS HUI	ME HEALTH OF IN	DIANA, LLC		CROWN	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	are not limited to, n	nultiple sclerosis (a disease in					
	which nerve damag	e disrupts communication					
	between the brain as	nd the body), an indwelling					
		d history of a recent urinary					
	tract infection, evid	enced an agency document					
		h Certification and Plan of					
		on period of 12/10/2020 -					
		ment had an area subtitled					
	"Orders of Discipling	ne and Treatments" which					
	stated, "Skilled nurs						
	co-morbid condition	ns including hypotension,					
	hypothyroidism, and	d other conditions that					
	present themselves	during the course of this					
	episode to identify of	changes and intervene to					
		ions Skilled nurse to perform					
	_	nent of genitourinary status					
		nimize complications of					
		illed nurse to provide					
	_	g management of disease					
	process including pa						
		uirements, and medication					
	regimen Skilled						
	_	indwelling urinary catheter					
		ease process including					
	_	ymptoms of complications,					
		and bag placement" This					
	1 ~	ed by the patient's physician					
	on 12/18/2020.						
	Record review evid	enced an agency document					
		ination Note Report" which					
	had an area that stat	-					
		ocument stated "RN called					
		inquire about foley catheter					
		ent] has coude placed currently					
		pt to place a foley, RN was					
		to the ER [Emergency Room]					
	i i	. Per [Person C], PT must see					
		ley catheter exchanged.					
	_	[Person A] stated [he/she]					
	Li sissii rij nomicu.	[] Samon [no/one]					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet Page 9 of 30

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157436	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(x3) date survey  COMPLETED  04/19/2021
	PROVIDER OR SUPPLIEF		1103	ET ADDRESS, CITY, STATE, ZIP 87 BROADWAY, SUITE C DWN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF cannot get [patient insisting RN do it. I " This note was enter Record review evid	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION #2] in to see urologist, RN reiterated doctor's orders ered by RN C on 12/11/2020. enced an agency document	ID PREFIX TAG	PROVIDER'S PLAN OF CI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	S SHOULD BE COMPLETION EAPPROPRIATE
	had an area that stat CLINICAL." The d flushed with white the bag. [Person D, info notified" This not 12/22/2020.	ocument stated "PT [patient] mucus present in urine in Foley ectious disease doctor]'s office ote was entered by RN C on			
	titled "Client Coord had an area that state CLINICAL." The de [Person A] on 12.24 nurse for a visit to a with the nurse, and patient's status from the patient's status from a MD [Doctor refused. The nurse of [Person C] and [the warranted further as the Emergency Room MD's recommendate not be taking [patie and hung up. Write back; however, unson second attempt Former Employee If failed to evidence defined to evidence def	enced an agency document ination Note Report" which ed "Note Type ocument stated "Spoke with 4.20. [Person A] requested assess patient. After speaking receiving an update on the atthe caregiver; I recommended equired further evaluation of Medicine]. [Person A] on the case spoke with y] agreed that the patient assessment and needed to go to m After I explained the ion [they] stated [they] would not #2] to the Emergency Room attempted to call [Person A] uccessful in reaching patient " This note was entered by 8, on 12/25/2020. Record review ocumentation of the date, time, e spoke to the patient's			
		enced an agency document ination Note Report" which ed "Note Type			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 10 of 30

	OF CORRECTION	IDENTIFICATION NUMBER  157436	î í	UILDING	00	COMPL 04/19/	ETED
	PROVIDER OR SUPPLIEF			11037 E	DDRESS, CITY, STATE, ZIP COD BROADWAY, SUITE C N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	CLINICAL." The domessage from careghas low output and PT and caregiver ac Department] PT in MD, PT to go to EI of above. Per CM, of MD orders, [Perswill take care of it caregiver that [Pershad exchanged Folewas entered by RN review failed to eviphysician referring Record review failed assessed conditions or intervened to minordered on the plan.  During an interview Clinical Manager in would be to triage to need came about, the contact the doctor to visit and go out.  During an interview the administrator coseen on 12/22/2020 to assess the patient A and the patient's on 12/26/2020, and until 12/28/2020, 4	cocument stated "RN received giver and [Person A] that Foley bulge present to pelvic region. Idvised to go to ED [Emergency refused. [Person C] paged. Per D. CM [case manager] notified contacted [Person A] to notify son A] refused and stated "I" "RN received message from on E, patient's family member] by catheter. This document C, on 12/26/2020. Record dence an order from the the patient to a urologist. Id to evidence a skilled nurse which presented themselves mimize complications as of care.  If on 4/15/2021, at 4:24 PM, the adicated the process for on-call the patient via telephone, if a men the on-call clinician can be put in a PRN [as needed]  If on 4/16/2021, at 11:02 AM, onfirmed the patient had been person A requested a nurse on 12/24/2020. Then, Person caregiver requested assistance the patient was still not seen days after the initial request. Indicated the nurse was					
	410 IAC 17-12-3(c)	)(1)(A)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet Page 11 of 30

06/23/2021 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 04/19/2021 157436 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11037 BROADWAY, SUITE C HRS HOME HEALTH OF INDIANA, LLC CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE G 0484 484.50(e)(1)(ii) Document complaint and resolution Bldg. 00 (ii) Document both the existence of the complaint and the resolution of the complaint; and G 0484 What action will we take to 04/19/2021 Based on record review and interview, the correct the deficiency cited? administrator failed to ensure all complaints were EDUCATION: All clinicians and documented with a resolution in 1 of 2 discharged Clinical Manager were in-serviced records which contained complaints. (#2) on the Complaint Reporting Policy. Clinicians are to report any The findings include: and all patient complaints to their direct report and include them in An agency policy, number 9-003, titled their documentation within the "Complaint/Grievance Process" revised December patient's chart. Clinical Manager 2019, stated "PURPOSE ... To set forth guidelines will be responsible for logging said for the resolution of patient concerns, complaints in the agency's dissatisfaction, or complaints and to protect Complaint Log along with their patient and family rights... Policy... Any difference timely resolutions and of opinion, dispute, or controversy between a communication to the patient and patient or family/caregiver or patient family. representative and HRS Home Health of Indiana LLC concerning any aspect of services or the Who is responsible to application of policies or procedures will be implement the corrective considered a grievance. The ... Administrator will action? be informed of situations that may become Administrator detrimental to good patient relations and will be committed to maintaining a consistently high level What is the monitoring process of patient relations. This grievance procedure will we will put into place to ensure be included in the Bill of Rights document given implementation and to each patient upon admission. The organization effectiveness of this corrective will investigate complaints regarding treatment or action plan? care, mistreatment, neglect ... by anyone Administrator will perform weekly furnishing services on behalf of the organization audits of 100% of the agency's ... PROCEDURE ... 1. ... The supervisor will Complaint Log to ensure investigate the grievance within five (5) days after compliance and consistency. receipt of such grievance and will make every During the audit, each complaint effort to resolve the grievance to the patient will be reviewed to confirm a timely satisfaction. Verbal or written response with resolution is present in 100% of complaint resolution will be communicated to the instances. If a resolution is

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 12 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		157436	B. WI	ING		04/19/	/2021
NAME OF E	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
			11037 BROADWAY, SUITE C				
HRS HO	ME HEALTH OF IN	IDIANA, LLC		CROWN POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 *	ember and be documented in			absent, re-education will be		
		vithin 10 days of receipt 4.			provided to the Clinical Manag		
		y action taken will be			and a resolution will be compl	eted	
		omplaint form 6. Resolution			as soon as possible and		
		communicated to the patient or			documented accordingly. Rev		
	_	ve filing the complaint within			will continue in accordance wi	th	
		e complaint 10. All			the corrective actions.		
		logged, tracked, trended, and					
	illed in the perform	nance improvement office"					
	An agency policy,	number 9-005, titled "Bill of					
		cember 2019, stated "PURPOSE					
	_	vareness of patient rates and					
	_	to assist patients in making					
		g care Ann for active					
	participation in plan	nning POLICY Each					
	patient will be an a	ctive, informed participant in					
	his/her plan of care	. To ensure this process, the					
	patient will be emp	owered with certain rights in					
	responsibilities as o	described PROCEDURE 2.					
	The patient Bill of	Rights statement defines the					
	right of the patient	to: 2. B. Voice grievances					
	regarding treatment	t or care that is (or fails to be)					
		ling the lack of respect for					
	1	who is furnishing services on					
	I -	ization and must not be					
		nination or reprisal for doing so					
	C. Receive an i	- ·					
		nplaints made by the patient or					
		or Guardian regarding					
		nat is (or fails to be) furnished,					
		f respect for patients property					
	1	ng services on behalf of the					
	_	nust document both the					
		mplaint and the resolution of					
		. The right to voice a complaint					
	_	ng care or service. The					
	I	r sources to receive questions					
	and complaints and	l assist in resolution"					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 13 of 30

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		157436	B. WI	NG		04/19/2021	
		1	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	t .			BROADWAY, SUITE C		
HRS HO	ME HEALTH OF IN	DIANA LLC			N POINT, IN 46307		
				01.011	· · · · · · · · · · · · · · · · · · ·		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		view on 4/16/2021, for patient					
		2/2020, diagnoses include, but					
		nultiple sclerosis (a disease in					
	_	e disrupts communication					
		nd the body), an indwelling					
		nd history of a recent urinary					
		enced an agency document					
		h Certification and Plan of					
		on period of 12/10/2020 - ument had an area subtitled					
		ne and Treatments" which					
		se to assess evaluate					
		ns including hypotension,					
		d other conditions that					
		during the course of this					
	1 ~	changes and intervene to					
		tions Skilled nurse to perform					
	1	nent of genitourinary status					
		nimize complications of					
		tilled nurse to provide					
		g management of disease					
	process including p						
		uirements, and medication					
	regimen Skilled	•					
	1 -	indwelling urinary catheter					
	management of disc	ease process including					
		ymptoms of complications,					
	perineal care, tube a	and bag placement" This					
	document was signed	ed by the patient's physician					
	on 12/18/2020.						
		enced an agency document					
		lination Note Report" which					
	had an area that stat						
		ocument stated "PT [patient]					
		mucus present in urine in Foley					
		ectious disease doctor]'s office					
		ote was entered by RN C on					
		review evidenced mucus in the					
	patient's urine, which	ch					
	l .		1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2IZE11 Facility ID: IN008882

If continuation sheet Page 14 of 30

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157436	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/19/2021
	ROVIDER OR SUPPLIER		11037 E	ADDRESS, CITY, STATE, ZIP COD BROADWAY, SUITE C N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	titled "Client Coord had an area that stat CLINICAL." The d [Person A] on 12.22 nurse for a visit to a with the nurse, and patient's status from the patient's status from a MD [Doctor refused. The nurse of [Person C] and [the warranted further as the Emergency Roo MD's recommendat not be taking [patienand hung up. Writer back; however, unso on second attempt Former Employee Efailed to evidence d and which employe physician. Record review evid titled "Client Coord had an area that stat CLINICAL." The d message from careghas low output and PT and caregiver accord per CM, of MD orders, [Perswill take care of it." caregiver that [Perswill take care of it." caregi	ocument stated "Spoke with a.20. [Person A] requested ssess patient. After speaking receiving an update on the athe caregiver; I recommended equired further evaluation of Medicine]. [Person A] on the case spoke with any agreed that the patient sessment and needed to go to a man and the case spoke with a sessment and needed to go to a stempt of the case spoke with a sessment and needed to go to a stempt of the case spoke with a sessment and needed to go to a stempt of the case spoke with a sessment and needed to go to a stempt of the sessment and needed to			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 15 of 30

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 157436	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  04/19/2021
	PROVIDER OR SUPPLIER ME HEALTH OF INDIANA, LLC	11037 E	ADDRESS, CITY, STATE, ZIP COD BROADWAY, SUITE C N POINT, IN 46307	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	was entered by RN C, on 12/26/2020. Record review failed to evidence an order from the physician referring the patient to a urologist. Record review failed to evidence this incident was documented in the complaint log.			
	During an interview on 4/15/2021, at 4:24 PM, the Clinical Manager indicated the process for on-call would be to triage the patient via telephone, if a need came about, then the on-call clinician can contact the doctor to put in a PRN (as needed) visit and go out.			
	During an interview on 4/16/2021, at 11:02 AM, the administrator confirmed the patient had been seen on 12/22/2020, Person A requested a nurse assess the patient on 12/24/2020, Person A and the patient's caregiver requested assistance on 12/26/2020, and the patient was not seen until 12/28/2020. The administrator indicated the nurse was following the doctor's orders. The administrator indicated they were unsure why Former Employee B, would not have logged these issues as complaints.			
	410 IAC 17-12-3(c)(2)			
G 0572 Bldg. 00	484.60(a)(1) Plan of care 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 podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 16 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/19/2021 157436 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11037 BROADWAY, SUITE C HRS HOME HEALTH OF INDIANA, LLC CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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. Based on record review and interview, the home G 0572 What action will we take to 04/19/2021 health agency failed to ensure the medical plan of correct the deficiency cited? care was individualized to include all medications EDUCATION: All clinicians and and indications that were prescribed as needed in Clinical Manager were in-serviced 3 of 3 clinical records reviewed. (#1, #2, #3) on the consistent, proper logging of patient medication, their use, The findings include: and frequency. Implementation of medication reconciliation tracking 1. An agency policy, number 1-003, titled process. "Physician Participation in Plan of Care" revised December 2019, stated, "PURPOSE ... To provide Who is responsible to guidelines for the physician's participation in implement the corrective home health care services ... POLICY ... A physician will direct the care of every home health Clinical Manager with oversight care patient admitted for service. The attending from Administrator physician will certify that medical, skilled, rehabilitative, and social services provided by the What is the monitoring process organization are medically necessary and meet the we will put into place to ensure requirements to be covered by Medicare ... implementation and PROCEDURE ... 1. Physician (or other authorized effectiveness of this corrective licensed independent practitioner) orders will be action plan? individualized, based on patient's needs, and Clinical manager will review include: ... C. medications to be administered medication reconciliation and/ or monitored ...." documentation for the two weeks post-corrective action 2. An agency policy, number 2-024, titled implementation to ensure 100% "Safe/Effective Use of Medications" revised compliance. If the criteria is met, December 2019, stated, "PURPOSE ... To provide review frequency will decrease to guidelines for the instruction of 50% of medication reconciliation patients/family/caregivers regarding the safe, documentation for the subsequent effective use of medication ... To promote correct two weeks, where 100% administration of medication by patients and compliance will remain the families/caregivers ... POLICY ... Patients and expectation. Thereafter, a monthly family/ caregivers will receive information audit will be conducted on 10% of regarding the safe and effective use of medication reconciliation

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 17 of 30

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		157436	B. W	ING		04/19/2021	
		<u> </u>		CTREET	IDDREGG CHTV CT TE TO COP		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
LIBOLIO	ME HEALTH OF '''	DIANA II C			BROADWAY, SUITE C		
HKS HO	ME HEALTH OF IN	DIANA, LLC		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	medications, in acc	ordance with applicable			documentation to ensure		
	organization policie	es PROCEDURE 2. The			continued compliance.		
	components of the	medication assessment used			Any discrepancy within the		
	to determine patien	t and family/caregiver			clinician documentation will re	sult	
	knowledge and skil	l related to medication			in re-education to the clinical s	staff	
	administration will	include, but will not be limited			in accordance with the correct	ive	
	to: A. Name, dosag	ge, route, duration, time and			action above.		
	usage of medication	n, intended use as well as					
	expected actions of	drug therapy K. Other					
	information, as app	licable"					
	3. An agency polic	y, number 8-020, titled					
	"Regulatory Compliance" revised December 2019,						
	stated, "PURPOSE	To ensure compliance with					
	local, state, federal,	and other regulatory bodies					
	POLICY The org	ganization will maintain evidence					
	of regulatory comp	liance, including but not limited					
	to: 12. profession	onal standards and principles					
	A. Federal regulation	ons B. State practice acts					
	C. Commonly acce	pted health standards					
	established by nation	onal organizations, boards and					
	councils "						
	4. Clinical record r	review on 4/16/2021, for patient					
	#1, start of care 4/9	/2021, diagnosis of atrial					
	fibrillation [irregula	ar heartbeat when the upper and					
		at out of order], evidenced a					
		ome Health Certification and					
	Plan of Care" for ce	ertification period 4/9/2021 -					
	6/7/2021. This docu	ument had an area subtitled					
	"Medications" which	ch stated "Glipizide					
	[anti-diabetic medic	=					
		nedication] and Simvistatin					
	-	cholesterol]" Record review					
	_	of care evidenced the patient					
	was taking 3 medic	ations.					
		lenced an agency document					
		eport" from 4/9/2021, which					
	was signed by RN [	[registered nurse] D. This					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet Page 18 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		157436	B. W	ING		04/19/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				BROADWAY, SUITE C		
пре поі	ME HEALTH OF IN	DIANA LLC			N POINT, IN 46307		
TIKSTIO	WE HEALTH OF IN	DIANA, LLC		CKOWI	1 FOINT, IN 40307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	document had an ar	ea subtitled "Narrative" which					
	stated "Patient repor	rts no pain but takes Tylenol					
	[Non-Steroidal Anti	-Inflammatory Drug]"					
	Record review faile	d to evidence "Tylenol" was					
	listed under "Medic	ations" on the medical plan of					
	care. Record review	v failed to evidence the plan of					
	care was individual	ized to include all medications					
	and indications for	which they were being used					
	by the patient.						
	5. Clinical record re	eview on 4/16/2021, for patient					
	#2, start of care 8/12	2/2020, primary diagnosis of					
	multiple sclerosis,	evidenced an agency					
	document titled, "H	ome Health Certification and					
	Plan of Care" for ce	ertification period 12/10/2020 -					
	2/7/2021. This docu	ment had an area subtitled					
	"Medications" whic	h stated "Hydrocodone					
		ne] 5 MG [milligrams]-					
		neric name for Tylenol] 325					
	MG Tablet Oral	tablet Every 8 Hours/PRN [as					
		ons: For Up To 7 Days					
	_	20 Gram/30 ML [milliliter] Oral					
		Times Daily/PRN					
		pain medication] 5 MG Tablet					
		RN Instructions: For up to 7					
	1	sleep aid medication] 10 MG					
		'RN" This document had an					
		ers of Discipline and					
		stated, "Skilled nurse to					
		norbid conditions including					
		nyroidism, and other					
		ent themselves during the					
	_	de to identify changes and					
		ze complications Skilled					
		servation/assessment of					
	•	and intervene to minimize					
	-	sease process. Skilled nurse to					
	_	regarding management of					
	1 ~	uding pathophysiology,					
	_	uirements, and medication					
	100	,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet Page 19 of 30

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157436	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COMP	E SURVEY LETED 0/2021
	PROVIDER OR SUPPLIER		11037	ADDRESS, CITY, STATE, ZIP CO BROADWAY, SUITE C N POINT, IN 46307	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
TAG	regimen Skilled patient/caregiver in management of disc catheter, sign and syperineal care, tube a document was signed on 12/18/2020. Rec PRN medications of individualized to inwhich they were proceed to the patient's region of the patient's status from the patient's status	nurse to instruct indwelling urinary catheter case process including ymptoms of complications, and bag placement" This ed by the patient's physician ord review failed to evidence all in the medical plan of care were clude specific indications for escribed.  enced an agency document ination Note Report" which ed "Note Type ocument stated "PT [patient] mucus present in urine in Foley ectious disease doctor]'s office office was entered by RN C on review evidenced mucus in the eth is an indication of an eview failed to evidence Person ysician to be notified.	TAG		TOO MATE	DATE
	[Person C] and [the warranted further as the Emergency Roo MD's recommendat not be taking [paties	on the case spoke with y] agreed that the patient seessment and needed to go to m After I explained the ion [they] stated [they] would nt #2] to the Emergency Room r attempted to call [Person A]				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 20 of 30

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157436	ľ	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 04/19/	ETED
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
HRS HO	ME HEALTH OF IN	DIANA, LLC			N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
ine	back; however, unst on second attempt former employee B	uccessful in reaching patient " This note was entered by		ino			BAIL
	titled "Client Coord had an area that stat CLINICAL." The d	ination Note Report" which red "Note Type ocument stated "RN received					
	has low output and PT and caregiver ac	tiver and [Person A] that Foley bulge present to pelvic region. lvised to go to ED [Emergency refused. [Person C] paged. Per					
	MD, PT to go to EI of above. Per CM, of of MD orders, [Pers will take care of it." caregiver that [patie exchanged Foley ca	O. CM [case manager] notified contacted [Person A] to notify son A] refused and stated, "I RN received message from ent's family member] had atheter. This document was					
	failed to evidence a referring the patient failed to evidence a	n 12/26/2020. Record review n order from the physician to a urologist. Record review n on call skilled nurse s new onset condition as of care.					
	the administrator coseen on 12/22/2020 assess the patient or the patient's caregiv 12/26/2020, and the 12/28/2020; 4 days	on 4/16/2021, at 11:02 AM, onfirmed the patient had been person A requested a nurse in 12/24/2020, Person A and rer requested assistance on expatient was not seen until later. The administrator was following the doctor's					
	the administrator in	-					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 21 of 30

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157436		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/19/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 11037 BROADWAY, SUITE C CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	#3, start of care 10/ liver transplant, evidence of titled, "Home Healt Care" for certificati 11/29/2020. This do "Medications" which MG 2 Tablet Even [opioid pain medici 10 MG - 325 MG T Hours/PRN" Reall PRN medication were individualized for which they were  During an interview the Clinical Manage	eview on 4/16/2021, for patient 1/2020, primary diagnosis of denced an agency document the Certification and Plan of on period 10/1/2020 - boument had an area subtitled the stated "Acetaminophen 325 try 6 Hours/PRN Norco and Tylenol combination] Tablet Oral 1 tablet Every 4 toord review failed to evidence as on the medical plan of care at to include specific indications to prescribed.  For on 4/16/2021, at 10:39 AM, or indicated PRN medications cations for when they are to be					
G 0682 Bldg. 00	practice, including precautions, to pre infections and con Based on observation failed to ensure all of precautions to preve	on In Prevention. Illow accepted standards of the use of standard event the transmission of inmunicable diseases. In the home health agency employees used standard ent the transmission of inmunicable diseases for 1 of 1 type D)	G 0682	What action will we take to correct the deficiency cited? EDUCATION: All clinicians will complete Infection Control education with post-course testing, per organization polici and procedures. They will also receive one on one field-based	es o		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet Page 22 of 30

06/23/2021 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 04/19/2021 157436 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11037 BROADWAY, SUITE C HRS HOME HEALTH OF INDIANA, LLC CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE An agency policy, number 7-001, titled "Infection education via their preceptor and Control Plan" revised December 2019, stated Lead RN; which will include "PURPOSE ... To delineate an infection control infection control scenarios during plan to meet the following goals: ... 2. Guide in-home visits. Lead RN will also organization personnel in the care and services perform quarterly joint visits and they provide in relation to infection control competency will be assessed based on the "Performance practices ... 5. Comply with all applicable local, state, and federal regulations, including, but not Observation Report" as it pertains limited to: A. State and federal OSHA to Infection Control. [Occupational Safety and Health Administration] mandates ... B. CDC [Center for Disease and Who is responsible to Control] recommendations and guidelines ... implement the corrective POLICY ... HRS Home Health of Indiana LLC is action? committed to reducing the risk of acquisition and Administrator transmission of health care associated infections (HAIs). recognized prevention in control What is the monitoring process mechanisms will be implemented for planning, we will put into place to ensure surveillance, identification, prevention controls, implementation and and reporting procedures ... Definitions ... The effectiveness of this corrective following definitions describe terms used by HRS action plan? Home Health of Indiana LLC throughout this Lead RN will perform joint visits to section ... 11. Decontamination: The use of 25% of clinician staff on a physical or chemical means to remove, inactivate, quarterly basis to ensure or destroy blood borne pathogens on a surface or compliance with the HRS Infection item to the point where they are no longer capable Control policy and procedure and of transmitting infectious particles, and the the organization's Continuous surface or item is rendered safe for handling, use, Quality Improvement program. or disposal ... 15. Hand Hygiene: A general term During each joint visit, that applies to either hand washing, antiseptic competency will be assessed hand wash, antiseptic hand rub, or surgical hand based on the "Performance antisepsis ... 24. Personal Protective Equipment Observation Report" as it pertains (PPE): Specialized clothing or equipment worn by to Infection Control. The clinician personnel for protection against a hazard ... 30. will be evaluated on the 11 items Standard Precautions: An approach to infection outlined in the "Performance Area" control where all human blood and certain human and must receive a passing score body fluids are treated as if known to be of at least 90%. infectious for HIV [human immunodeficiency Administrator will perform an audit virus], HBV [hepatitis B virus], and other blood within 30 days of implementation borne pathogens ... PROCEDURE ... 1. HRS Home to show a 100% pass rate of Health of Indiana LLC will educate all personnel infection prevention and control

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 23 of 30

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		157436	B. W	ING		04/19/20	021	
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER			11037 E	BROADWAY, SUITE C			
HRS HO	ME HEALTH OF IN	DIANA, LLC		CROW	N POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE (	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE	
		policies, procedures, and their implementation as contained			policies and procedures. If the			
	_	ion. New personnel will			clinician does not pass, they w receive a Coaching Note from			
	_	e standard precautions (see			Lead RN, must repeat the	lile		
		ons" policy No. 7-007) in their			coursework under the supervise	sion		
		2. Personnel will be			of the Lead RN/Administrator,			
	_	the basics of transmission of			must repeat the joint visit. This			
	ı ^	ts and personnel, blood borne			monitoring will be a permanen			
		standard precautions,			part of quarterly Continuous			
	infectious waste ma	nagement, and other infection			Performance Improvement.			
	control procedures	"						
	" " "	number 7-007, titled "Standard						
		d December 2019, stated						
		educe the risk of exposure to						
		infections when caring for						
	1 ~	Organization personnel will ring precautions and will						
		I family caregivers in infection						
	_	as appropriate to the patients						
	_	EDURE: General						
		Hygiene 1. Hand hygiene						
		prevent cross contamination						
	_	and personnel (see also						
		olicy No. 7-009.) Personal						
	protective equipmen	nt 1. Gloves: A Gloves						
ı	are to be worn when							
		or surfaces 5. Handling any						
		10. Cleaning of body fluids						
		n procedures C. Gloves are						
	_	. Between tasks and						
	procedures on the sa	ame patient"						
ı	An aganay malia :-	number 7 000 titled "Head						
		number 7-009, titled "Hand ecember 2019, stated						
ı		revent cross-contamination						
		red infections POLICY						
	_	g care in the home setting will						
		hands, per the most recently						
		ulations and guidelines for						
	1	<b>61111-6</b>						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 24 of 30

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  157436		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/19/2021		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 11037 BROADWAY, SUITE C CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	alcohol-based hand decontamination us should be performe contact with patient patient's intact skin pressure or lifting a with inanimate obje	and decontamination with an rub 3. Hand ing an alcohol-based hand rub d: A. Before Having direct s C. After contact with a (when taking a pulse, blood patient) F. After contact cts (including medical numediate vicinity of the patient					
	Technique" revised "PURPOSE To d maintaining a clean and preventing cros As part of the infect HRS Home Health consistently implen efficient use of the used in caring for p Technique 3. As and/or equipment n removed from the b completed, reusable using alcohol, soap appropriate solution equipment and supp	n, hands will be washed, and blies will be returned to the ll be decontaminated prior to					
	of a home visit for p 4/9/2021, diagnosis heartbeat, often rap flow), RN D entered instructed by the pa	on on 4/16/2021, at 2:00 PM, patient #1, start of care of Atrial Fibrillation (irregular id and causes poor blood d the patient's home as tient via telephone. At 2:06 a barrier on the patient's couch,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet

Page 25 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		157436	B. WING			04/19/2021	
		<u> </u>	STR	EET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			BROADWAY, SUITE C		
HRS HOI	ME HEALTH OF IN	DIANA, LLC			N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAC	ř	DEFICIENCY)		DATE
	* *	ed hand rub (ABHR), placed					
	_	on top of barrier, and then					
		D went into their work bag to					
		er, blood pressure cuff, and					
	-	e patient could not find their					
		ed by the agency and RN D					
		atient by looking underneath					
		in bedrooms. According to the					
		9, RN D should have changed					
	-	d after touching inanimate					
	· ·	I, RN D checked the patient's,					
	temperature, blood pressure, Pulse Oximetry,						
	Heart Rate. RN D placed blood pressure cuff,						
	thermometer, and pulse oximeter on the barrier, then picked up the tablet and began to document.						
		blet on the barrier and picked					
	-	e. The nurse placed the					
		eatient's chest, then to the					
		ND placed stethoscope on					
	-	ed up the tablet to document.					
	_	7-007, RN D should have					
		giene in between performing					
		atient. At 2:30 PM, RN D					
	_	vipes from work bag and began					
		oximeter, thermometer, blood					
		tethoscope, then placed the					
		t in a plastic bag. RN D placed					
		the work bag, removed their					
		d hands with ABHR.					
	-	to evidence RN D changed					
	gloves after patient	contact, between performing					
	tasks on the same p	atient, after touching					
		lecontaminating reusable					
		or to returning decontaminated					
	items into the work	bag.					
		57 PM, the administrator and					
	_	ere notified of the observations					
	during the home vis	sit for patient #1.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2IZE11

Facility ID: IN008882

If continuation sheet Page 26 of 30

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  157436		A. BUILDING B. WING	COMPLETED 04/19/2021		
	PROVIDER OR SUPPLIER		11037	ADDRESS, CITY, STATE, ZIP COD BROADWAY, SUITE C IN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
N 0000	410 IAC 17-12-1(m	)			
Bldg. 00	conducted at HRS E. Indiana Department 410 IAC 17.  Complaint # IN0034 findings	estigation survey was  Home Health of IN LLC by the of Health in accordance with  45294 - substantiated with	N 0000	Per direction above, no action required	n
	•	HRS Home Health of IN LLC in compliance with 410 IAC			
N 0488 Bldg. 00	must develop and requiring a notice of the patient, the particular or other individual care at least fifteer the services are st	nce improvement A home health agency implement a policy of discharge of service to tient's legal representative, responsible for the patient's n (15) calendar days before copped.			
	the following circui (1) The health, sa home health agen- immediate and sig	nis rule does not apply in mstances: fety, and/or welfare of the cy's employees would be at nificant risk if the home tinued to provide services			

State Form Event ID: 2IZE11 Facility ID: IN008882 If continuation sheet Page 27 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPLETED	
		157436	B. WING 04/19/2021			/2021	
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			BROADWAY, SUITE C		
HRS HO	ME HEALTH OF IN	DIANA LLC		CROWN POINT, IN 46307			
111.0110		DI UVA, LEO		CINOWI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	to the patient.						
		fuses the home health					
	agency's services						
		services are no longer					
	reimbursable base						
		quirements and the home					
		orms the patient of					
		rces to assist the patient					
	following discharg						
	(4) The patient no longer meets applicable						
	regulatory 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.		NI O	100	What action will we take to		04/19/2021
	Rased on record rev	view, the home health agency	N 04	+00	correct the deficiency cited?		04/19/2021
		nd implement a 15-day			EDUCATION: All clinicians we		
	discharge policy.	id implement a 13-day			in-serviced on the Indiana stat		
	disenarge poney.				15-day Discharge Policy.		
	The findings includ	e:			POLICY UPDATE: Agency Po	dicy	
	The intended				and Procedure manual has be		
	An agency policy, i	number 9-005, titled "Bill of			updated as of April 19th to inc		
		cember 2019, stated "PURPOSE			the 15-day discharge notificati		
	_	vareness of patient rates and			PATIENT INFORMATION		
	_	to assist patients in making			PACKET: Discharge policy an	d	
	decisions regarding	-			procedure were updated and		
		nning POLICY Each			added within the Patient Bill of	f	
	patient will be an ac	ctive, informed participant in			Rights.		
	his/her plan of care	. To ensure this process, the					
	patient will be emp	owered with certain rights in			Who is responsible to		
	_	lescribed PROCEDURE 2.			implement the corrective		
	_	Rights statement defines the			action?		
		to: 2 AA. The			Administrator		
	organization's trans	fer and discharge policies"					
					What is the monitoring proce		
		igency's sample admission			we will put into place to ensu	ıre	
		policy titled "HRS HOME			implementation and		
		ARGE CRITERIA" which stated			effectiveness of this correcti	ve	
	"1. Services will be	e terminated when the patient			action plan?		

State Form Event ID: 2IZE11 Facility ID: IN008882 If continuation sheet Page 28 of 30

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2021 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  157436	A. BUILDING B. WING	00	COMPLETED 04/19/2021				
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 11037 BROADWAY, SUITE C					
HRS HOI	ME HEALTH OF INI	DIANA, LLC		N POINT, IN 46307					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5)				
TAG		CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE				
1110		ore of the discharge criteria	1110	Agency performs 100% week					
	1 1	patient's medical or treatment		audit of patient Bill of Rights a	•				
	program that require	es a change to a different level		consent forms, which					
	of care B. A cha	ange in the patient's condition		acknowledges receipt of patie	nt				
	-	vices other than that provided		education for agency DC police	су				
		If the patient acuity requires		and procedure including the					
		e that the organization cannot		15-day notification requirement	nt.				
		ration shall arrange for a safe							
	** *	sfer to another organization							
	•	needed level of care D.							
	_	y/caregiver riff uses, r elects to transfer to another							
		family/caregiver refuses to							
	_	ng the objectives of home care							
	G. The patient and/or family display disruptive,								
	abusive, and uncoop								
	_	. For a patient requiring							
		istance will be given to the							
	-	earegiver in order to manage							
	-	ds after the organization							
	services are disconti	inued 5. The decision to							
	terminate or reduce	services must be documented							
	in the clinical record	d citing the circumstances in							
	notification to the pa	atient, the responsible							
		representative, and the							
		fforts to resolve problems							
		rill also be documented in the							
		patient will be provided							
		for other home health							
		lers if continued care is							
		I supervisor or designee is decision and the required							
		decision and the required ne decision to terminate							
		e patient's behavior, the							
		ersons in the home, or							
		al record must reflect the							
		fication of the problems							
	-	ssessment of the situation							
		with the organization							
		e physician responsible for the							
	_	<u> </u>							

State Form Event ID: 2IZE11 Facility ID: IN008882 If continuation sheet Page 29 of 30

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157436	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/19/2021			
NAME OF PROVIDER OR SUPPLIER  HRS HOME HEALTH OF INDIANA, LLC				STREET ADDRESS, CITY, STATE, ZIP COD 11037 BROADWAY, SUITE C CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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)  DATE  (X5)  COMPLETI  DATE		COMPLETION	
	plan of care D. A plan to resolve the issues E. Results of the plan implementation 9. DISCHARGE FOR CAUSE: If the patient is being discharged for cause, the physician(s) issuing orders for the plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge will be notified. For Medicare in Medicare HMO patients, the organization will issue a Notice of Medicare Non-coverage (NOMCNC) at least 48 hours prior to termination"  Record review failed to evidence a policy or implementation of the 15-day discharge requirement for the State of Indiana.  On 4/16/2021, at 4:30 PM, the administrator and clinical manager were informed of the 15-day discharge policy required by the State of Indiana.							

State Form Event ID: 2IZE11 Facility ID: IN008882 If continuation sheet Page 30 of 30