STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	157436	A. BUILDING 00 B. WING	04/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HRS HOME HEALTH OF INDIANA, LLC	11037 BROADWAY, SUITE C CROWN POINT, IN 46307

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G 0000 Bldg. 00	This survey was a federal focused infection control and complaint investigation of a home health agency. Complaint # IN00345294 - substantiated with findings Survey Dates: 4/14/2021, 4/15/2021, 4/16/2021 Facility ID: 157436 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings.	G 0000	Per direction above, no action required	
G 0468 Bldg. 00	484.50(d)(5)(iii) Provide contact info other services (iii) Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and Based on record review and interview, the Administrator failed to provide contact information for other agencies or providers who would be able to provide care to 1 of 2 discharged patients. (#2) The findings include: An agency policy, number 1-006, titled "Admission Criteria and Process" revised December 2019, stated "PURPOSE ... To establish standards and a process by which a patient can be evaluated and accepted for admission ... POLICY ... A patient will be accepted for care based on consideration. Consideration will be	G 0468	**What action will we take to correct the deficiency cited?** EDUCATION: All field clinicians, transitional care coordinators and Clinical Manager were in-serviced on the Indiana state 15-day notification of discharge policy. Staff was also educated on the proper coordination of alternative services, in the event a transition plan is needed. POLICY UPDATE: Agency Policy and Procedure manual has been updated as of April 19th to include the 15-day discharge notification.	04/19/2021

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

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	given to the adequacy and suitability of organization personnel, resources to provide the required services, and the reasonable expectation that the patient's medical, nursing, rehabilitative, and social needs can be adequately met in the patient's place of residence ... A patient will be transferred to other resources if the organization cannot meet his/her needs ... Once a patient is admitted to service, the organization is responsible for providing care and services within its financial and service capabilities, mission, and applicable law and regulations. Review of the agency's admission packet, evidenced on page 12, "HRS HOME HEALTH DISCHARGE CRITERIA" which stated "1. Services will be terminated when the patient meets one or more of the discharge criteria: A. A change in the patient's medical or treatment program that requires a change to a different level of care. B. A change in the patient's condition requires care or services other than that provided by the organization. If the patient's acuity requires another level of care that the organization cannot provide, the organization shall arrange for a safe and appropriate transfer to another organization that can provide the needed level of care ... D. The patient or family/ caregiver refuses, discontinues care, or elects to transfer to another organization. E. The patient or family/ caregiver refuses to cooperate in attaining the objectives of homecare... G. The patient and/or family display disruptive abusive an uncooperative behavior ... PROCEDURE ... 5. The decision to terminate or reduce services must be documented in the clinical records citing circumstances in notification to the patient, the responsible family/ caregiver or representative, and the patient's position. Efforts to resolve problems prior to discharge will also be documented in the patients		PATIENT INFORMATION PACKET: Discharge policy and procedure was updated and added within the Patient Bill of Rights. DOCUMENTATION: In the event a patient's care exceeds what can be provided, communication to the MD and patient of the looming discharge will be documented in the chart. To ensure no lapse in care to the patient, the agency will work with the patient's MD to determine a transition plan (i.e. another home health agency, skilled nursing facility, etc.) that best suits the patient's/family's needs and wishes. Care will continue until the transition is complete. **Who is responsible to implement the corrective action?** Administrator **What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?** All cases requiring a transition plan will be discussed amongst the Administrator, Clinical Manager, physician, and patient prior to the transition taking place. This communication will be documented in the patient's chart and include the contact information for the identified services.	

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	record. The patient will be provided contact information for other home health agencies and providers if continued care is needed. The clinical supervisor or designee is accountable for the decision and the required documentation. If the decision to terminate services is due to the patient's behavior, the behavior of other persons in the home, or situation, the clinical record must reflect the following: A. identification of the problems encountered ... B. Assessment of the situation ... C. Communication with the organization management and the physician responsible for the plan of care ... D. A plan to resolve the issues ... E. Results of the plan implementation ...." Clinical Record Review on 4/16/2021, for patient #2, start of care 8/12/2020, diagnoses include, but are not limited to, multiple sclerosis (a disease in which nerve damage disrupts communication between the brain and the body), an indwelling urethral catheter, and history of a recent urinary tract infection, evidenced an agency document titled, "Home Health Certification and Plan of Care" for certification period of 12/10/2020 - 2/7/2021. This document had an area subtitled "Orders of Discipline and Treatments" which stated, "Skilled nurse to assess evaluate co-morbid conditions including hypotension, hypothyroidism, and other conditions that present themselves during the course of this episode to identify changes and intervene to 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		Administrator will inspect 100% of patient discharges for the first two weeks after the corrective action implementation to ensure contact information was provided during the transition planning conversations for alternative service options. These cases will be discussed during quarterly QAPI meetings to confirm compliance. If 100% compliance was achieved during the initial two-week inspection, the discharge audit will drop to 50% of discharged patients within the following two-week timeline. If compliance has been met for these two criteria, Administrator will maintain a monthly patient review of 10% of the agency's discharged patients. In the event information was not provided and/or not documented during an audit, the Administrator will reach out to the patient and MD to ensure their transition plan was successful and document this communication. Additionally, re-education will take place with the clinical staff and clinical manager regarding the corrective action above.	

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	document was signed by the patient's physician on 12/18/2020. Record review evidenced an agency document titled "Client Coordination Note Report" which had an that stated "Note Type ... CLINICAL." The document stated "RN [Registered Nurse] called [Person C, patient #2's physician] office to inquire about Foley catheter exchange, PT [patient] has coude [a type of catheter where the tip is bent to navigate passed blockages] placed currently and upon last attempt to place a Foley, RN was unable to, PT went to ER [emergency room] for Foley placement. Per [Person C], PT must see urologist to have Foley catheter exchanged. [Person A, patient #2's representative] notified. [Person A] states [they] cannot get [patient #2] in to see urologist, insisting RN do it. RN reiterated Doctor's orders.... " This note was entered by RN C on 12/11/2020. Record review evidenced an agency document titled "Client Coordination Note Report" which had an that stated "Note Type ... CLINICAL." The document stated "Spoke with [Person A] on 12.24.20. [Person A] requested nurse for a visit to assess patient. After speaking with the nurse, and receiving an update on the patient's status from the caregiver; I recommended the patient's status required further evaluation from a MD [Doctor of Medicine]. [Person A] refused. The nurse on the case spoke with [Person C] and [they] agreed that the patient warranted further assessment and needed to go to the Emergency Room ... After I explained the MD's recommendation [they] stated [they] would not be taking [Patient #2] to the Emergency Room and hung up. Writer attempted to call [Person A] back; however, unsuccessful in reaching patient on second attempt.... " This note was entered by Former Employee B, on			

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	12/25/2020. Record review failed to evidence documentation of the date, time, and which employee spoke to the patient's physician. Record review evidenced an agency document titled "Client Coordination Note Report" which had an that stated "Note Type ... CLINICAL." The document stated "RN received message from caregiver and [Person A] that Foley has low output and bulge present to pelvic region. PT and caregiver advised to go to ED [Emergency Department] ... PT refused. [Person C] paged. Per MD, PT to go to ED. CM [case manager] notified of above. Per CM, contacted [Person A] to notify of MD orders, [Person A] refused and stated "I will take care of it ." RN received message from caregiver that [Person E, patient's family member] had exchanged Foley catheter. This document was entered by RN C, on 12/26/2020. Record review evidenced an agency document titled "Client Coordination Note Report" which had an area that stated "Note Type ... CLINICAL." The document stated "DO NOT RE-ADMIT: D/T [due to] TO PATIENT COMPLEXITY, NEED OF LONG TERM CARE AND LACK OF MD INVOLVEMENT, WE WILL NOT BE ACCEPTING THIS PATIENT BACK ON SERVICE.... " This note was entered on 1/14/21 by the Administrator. An email chain was submitted during clinical record review at 11:07 AM. The original email was from RN C on 1/14/2021 at 9:56 AM, which stated "[Patient #2] being taken to the ER to [Entity E, a hospital] for having food stuck in [his/her] throat ..." A response from the Administrator on 1/14/2021, at 4:30 PM, stated "Team, please be aware that this is a case we will not be accepting back d/t the complexity and no designated care			

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	plan provided by the MD ... [Employee E, transitional care coordinator], please inform the hospital asap [as soon as possible] that the patient was active with us but will not be accepting him/her back. Please make sure they understand this and do not DC [discharge] him/her home thinking he already has HH [home health] established because we do not want [him/her] left in limbo ..." Record review failed to evidence the care team held case conferences to discuss discharge due to the increased complexity of the patient. Record review failed to evidence the patient was provided with contact information for other agencies/providers capable of handling the complexity of the patient. Another response from employee E on 1/20/2021, at 1:53 PM, stated "Just heard back from [Entity E] and they confirmed [he/she] WAS set up with a different home health. So we can discharge ...." Record review failed to evidence what the added complexity of the patient entailed. Record review failed to evidence the patient and/or family/caregiver was given contact information to other providers/agencies that would be able to better serve the patient. During an interview on 4/15/2021, at 4:24 PM, the Clinical Manager indicated the only skill the nurses were not trained on were ventilators (machine used to breath for a patient). The Administrator added the agency staff was used to getting patients from the hospital and are skilled in most complex cases, with the exception of ventilators. Record review evidenced the patient was not on a ventilator. During an interview on 4/15/2021, at 4:30 PM, the Administrator indicated the discharge process would begin during the admission, conduct case			

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	conferences throughout the certification period, ensure the patient's physician was aware, and inform the patient or representative a minimum of 48 hours prior to discharge. During an interview on 4/16/2021, at 11:07 AM, the Administrator indicated the patient had a history of being admitted to the hospital and would come home with greater issues that were more complex than before. They indicated the agency would try to contact the hospital case manager via email to have them find another home health agency for the patient. The Administrator indicated the patient would be discharged from the hospital and HRS Home Health would have to resume care. Documentation of attempts to contact the hospital case manager(s) were requested, but the Administrator indicated they could not find them.			
G 0480 Bldg. 00	484.50(e)(1)(i)(A) Treatment or care (i)(A) Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately; and Based on record review and interview, the agency failed to ensure patient care was furnished appropriately as ordered on the plan of care in 1 of 2 discharged patients. (#2) An agency policy, number 1-003, titled "Physician Participation in Plan of Care" revised December 2019, stated, "PURPOSE ... To provide guidelines for the physician's participation in home health care services ... POLICY ... A physician will direct the care of every home health care patient admitted for service. The attending physician will certify that medical, skilled, rehabilitative, and social services provided by the organization are medically necessary and meet the requirements to	G 0480	**What action will we take to correct the deficiency cited?** EDUCATION: All clinicians and Clinical Manager received re-education on the on-call/after-hours triage expectations/policy. - On-call Protocol i. Weekday/Weekend/Holiday Calls – On-call RN is required to take primary call and the Clinical Manager is secondary. ii. Triaging Calls – Based on the patient's needs, can	04/19/2021

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	be covered by Medicare ... PROCEDURE ... 1. Physician (or other authorized licensed independent practitioner) orders will be individualized, based on patient's needs, and include: ... B. Treatments and/or procedures needed, including type, frequency, duration, and goals ...." An agency policy, number 9-005, titled "Bill of Rights" revised December 2019, stated "PURPOSE ... To encourage awareness of patient rates and provide guidelines to assist patients in making decisions regarding care Ann for active participation in planning ... POLICY ... Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights in responsibilities as described ... PROCEDURE ... 2. The patient Bill of Rights statement defines the right of the patient to: ... 2. B. 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 organization and must not be subjected to discrimination or reprisal for doing so ... C. Receive an investigation by the organization of complaints made by the patient or the patient's family or Guardian regarding treatment or care that is (or fails to be) furnished, or regarding lack of respect for patients' property by anyone furnishing services on behalf of the organization, and must document both the existence of the complaint and the resolution of the complaint ... W. The right to voice a complaint or concern regarding care or service. The availability of other sources to receive questions and complaints and assist in resolution ...." Clinical Record Review on 4/16/2021, for patient #2, start of care 8/12/2020, diagnoses include, but		this be triaged over the phone v.s. performing a skilled visit v.s. calling 911 iii. If patient's needs cannot be determined or resolved via phone, RN may perform an on-call visit as appropriate and approved by Clinical Supervisor and the patient's MD. **Who is responsible to implement the corrective action?** Administrator **What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?** Clinical manager will receive daily morning updates from the on-call RN from the night prior. Clinical Manager will maintain a log of 100% on-call occurrences/calls from patients to ensure compliance and accuracy. Occurrences/calls will be present in the patient's chart. In the event an occurrence was not properly coordinated, then all clinical field staff will be re-educated on the On-call Protocol and expectations.	

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	are not limited to, multiple sclerosis (a disease in which nerve damage disrupts communication between the brain and the body), an indwelling urethral catheter, and history of a recent urinary tract infection, evidenced an agency document titled, "Home Health Certification and Plan of Care" for certification period of 12/10/2020 - 2/7/2021. This document had an area subtitled "Orders of Discipline and Treatments" which stated, "Skilled nurse to assess evaluate co-morbid conditions including hypotension, hypothyroidism, and other conditions that present themselves during the course of this episode to identify changes and intervene to minimize complications ... Skilled nurse to perform observation/assessment of genitourinary status and intervene to minimize complications of disease process. Skilled nurse to provide instruction regarding management of disease process including pathophysiology, nutritional/fluid requirements, and medication regimen ... 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 document was signed by the patient's physician on 12/18/2020. Record review evidenced an agency document titled "Client Coordination Note Report" which had an area that stated "Note Type ... CLINICAL." The document stated "RN called [Person C] office to inquire about foley catheter exchange, PT [patient] has coude placed currently and upon last attempt to place a foley, RN was unable to, PT went to the ER [Emergency Room] for foley placement. Per [Person C], PT must see urologist to have foley catheter exchanged. [Person A] notified. [Person A] stated [he/she]			

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	cannot get [patient #2] in to see urologist, insisting RN do it. RN reiterated doctor's orders.... " This note was entered by RN C on 12/11/2020. Record review evidenced an agency document titled "Client Coordination Note Report" which had an area that stated "Note Type ... CLINICAL." The document stated "PT [patient] flushed with white mucus present in urine in Foley bag. [Person D, infectious disease doctor]'s office notified ...." This note was entered by RN C on 12/22/2020. Record review evidenced an agency document titled "Client Coordination Note Report" which had an area that stated "Note Type ... CLINICAL." The document stated "Spoke with [Person A] on 12.24.20. [Person A] requested nurse for a visit to assess patient. After speaking with the nurse, and receiving an update on the patient's status from the caregiver; I recommended the patient's status required further evaluation from a MD [Doctor of Medicine]. [Person A] refused. The nurse on the case spoke with [Person C] and [they] agreed that the patient warranted further assessment and needed to go to the Emergency Room ... After I explained the MD's recommendation [they] stated [they] would not be taking [patient #2] to the Emergency Room and hung up. Writer attempted to call [Person A] back; however, unsuccessful in reaching patient on second attempt.... " This note was entered by Former Employee B, on 12/25/2020. Record review failed to evidence documentation of the date, time, and which employee spoke to the patient's physician. Record review evidenced an agency document titled "Client Coordination Note Report" which had an area that stated "Note Type ...			

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	CLINICAL." The document stated "RN received message from caregiver and [Person A] that Foley has low output and bulge present to pelvic region. PT and caregiver advised to go to ED [Emergency Department] ... PT refused. [Person C] paged. Per MD, PT to go to ED. CM [case manager] notified of above. Per CM, contacted [Person A] to notify of MD orders, [Person A] refused and stated "I will take care of it ." RN received message from caregiver that [Person E, patient's family member] had exchanged Foley catheter. This document 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 a skilled nurse assessed conditions which presented themselves or intervened to minimize complications as ordered on the plan of care. 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 to assess the patient on 12/24/2020. Then, Person A and the patient's caregiver requested assistance on 12/26/2020, and the patient was still not seen until 12/28/2020, 4 days after the initial request. The administrator indicated the nurse was following the doctor's orders. 410 IAC 17-12-3(c)(1)(A)			

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G 0484 Bldg. 00	484.50(e)(1)(ii) Document complaint and resolution (ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview, the administrator failed to ensure all complaints were documented with a resolution in 1 of 2 discharged records which contained complaints. (#2) The findings include: An agency policy, number 9-003, titled "Complaint/Grievance Process" revised December 2019, stated "PURPOSE ... To set forth guidelines for the resolution of patient concerns, dissatisfaction, or complaints and to protect patient and family rights... Policy... Any difference of opinion, dispute, or controversy between a patient or family/caregiver or patient representative and HRS Home Health of Indiana LLC concerning any aspect of services or the application of policies or procedures will be considered a grievance. The ... Administrator will be informed of situations that may become detrimental to good patient relations and will be committed to maintaining a consistently high level of patient relations. This grievance procedure will be included in the Bill of Rights document given to each patient upon admission. The organization will investigate complaints regarding treatment or care, mistreatment, neglect ... by anyone furnishing services on behalf of the organization ... PROCEDURE ... 1. ... The supervisor will investigate the grievance within five (5) days after receipt of such grievance and will make every effort to resolve the grievance to the patient satisfaction. Verbal or written response with complaint resolution will be communicated to the	G 0484	**What action will we take to correct the deficiency cited?** EDUCATION: All clinicians and Clinical Manager were in-serviced on the Complaint Reporting Policy. Clinicians are to report any and all patient complaints to their direct report and include them in their documentation within the patient's chart. Clinical Manager will be responsible for logging said complaints in the agency's Complaint Log along with their timely resolutions and communication to the patient and family. **Who is responsible to implement the corrective action?** Administrator **What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?** Administrator will perform weekly audits of 100% of the agency's Complaint Log to ensure compliance and consistency. During the audit, each complaint will be reviewed to confirm a timely resolution is present in 100% of instances. If a resolution is	04/19/2021

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	patient or family member and be documented in the complaint log within 10 days of receipt ... 4. Complaints and any action taken will be documented on a complaint form ... 6. Resolution information will be communicated to the patient or his/her representative filing the complaint within ten (10) days of the complaint ... 10. All complaints will be logged, tracked, trended, and filed in the performance improvement office...." An agency policy, number 9-005, titled "Bill of Rights" revised December 2019, stated "PURPOSE ... To encourage awareness of patient rates and provide guidelines to assist patients in making decisions regarding care Ann for active participation in planning ... POLICY ... Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights in responsibilities as described ... PROCEDURE ... 2. The patient Bill of Rights statement defines the right of the patient to: ... 2. B. 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 organization and must not be subjected to discrimination or reprisal for doing so ... C. Receive an investigation by the organization of complaints made by the patient or the patient's family or Guardian regarding treatment or care that is (or fails to be) furnished, or regarding lack of respect for patients property by anyone furnishing services on behalf of the organization, and must document both the existence of the complaint and the resolution of the complaint ... W. The right to voice a complaint or concern regarding care or service. The availability of other sources to receive questions and complaints and assist in resolution ...."		absent, re-education will be provided to the Clinical Manager and a resolution will be completed as soon as possible and documented accordingly. Reviews will continue in accordance with the corrective actions.	

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	Clinical Record Review on 4/16/2021, for patient #2, start of care 8/12/2020, diagnoses include, but are not limited to, multiple sclerosis (a disease in which nerve damage disrupts communication between the brain and the body), an indwelling urethral catheter, and history of a recent urinary tract infection, evidenced an agency document titled, "Home Health Certification and Plan of Care" for certification period of 12/10/2020 - 2/7/2021. This document had an area subtitled "Orders of Discipline and Treatments" which stated, "Skilled nurse to assess evaluate co-morbid conditions including hypotension, hypothyroidism, and other conditions that present themselves during the course of this episode to identify changes and intervene to minimize complications ... Skilled nurse to perform observation/assessment of genitourinary status and intervene to minimize complications of disease process. Skilled nurse to provide instruction regarding management of disease process including pathophysiology, nutritional/fluid requirements, and medication regimen ... 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 document was signed by the patient's physician on 12/18/2020. Record review evidenced an agency document titled "Client Coordination Note Report" which had an area that stated "Note Type ... CLINICAL." The document stated "PT [patient] flushed with white mucus present in urine in Foley bag. [Person D, infectious disease doctor]'s office notified ...." This note was entered by RN C on 12/22/2020. Record review evidenced mucus in the patient's urine, which			

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	Record review evidenced an agency document titled "Client Coordination Note Report" which had an area that stated "Note Type ... CLINICAL." The document stated "Spoke with [Person A] on 12.24.20. [Person A] requested nurse for a visit to assess patient. After speaking with the nurse, and receiving an update on the patient's status from the caregiver; I recommended the patient's status required further evaluation from a MD [Doctor of Medicine]. [Person A] refused. The nurse on the case spoke with [Person C] and [they] agreed that the patient warranted further assessment and needed to go to the Emergency Room ... After I explained the MD's recommendation [they] stated [they] would not be taking [patient #2] to the Emergency Room and hung up. Writer attempted to call [Person A] back; however, unsuccessful in reaching patient on second attempt.... " This note was entered by Former Employee B, on 12/25/2020. Record review failed to evidence documentation of the date, time, and which employee spoke to the patient's physician. Record review failed to evidence this incident was documented in the complaint log. Record review evidenced an agency document titled "Client Coordination Note Report" which had an area that stated "Note Type ... CLINICAL." The document stated "RN received message from caregiver and [Person A] that Foley has low output and bulge present to pelvic region. PT and caregiver advised to go to ED [Emergency Department] ... PT refused. [Person C] paged. Per MD, PT to go to ED. CM [case manager] notified of above. Per CM, contacted [Person A] to notify of MD orders, [Person A] refused and stated, "I will take care of it." RN received message from caregiver that [Person E, patient's family member] had exchanged Foley catheter. This document			

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	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			

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	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 health agency failed to ensure the medical plan of care was individualized to include all medications and indications that were prescribed as needed in 3 of 3 clinical records reviewed. (#1, #2, #3) The findings include: 1. An agency policy, number 1-003, titled "Physician Participation in Plan of Care" revised December 2019, stated, "PURPOSE ... To provide guidelines for the physician's participation in home health care services ... POLICY ... A physician will direct the care of every home health care patient admitted for service. The attending physician will certify that medical, skilled, rehabilitative, and social services provided by the organization are medically necessary and meet the requirements to be covered by Medicare ... PROCEDURE ... 1. Physician (or other authorized licensed independent practitioner) orders will be individualized, based on patient's needs, and include: ... C. medications to be administered and/ or monitored ...." 2. An agency policy, number 2-024, titled "Safe/Effective Use of Medications" revised December 2019, stated, "PURPOSE ... To provide guidelines for the instruction of patients/family/caregivers regarding the safe, effective use of medication ... To promote correct administration of medication by patients and families/caregivers ... POLICY ... Patients and family/ caregivers will receive information regarding the safe and effective use of	G 0572	**What action will we take to correct the deficiency cited?** EDUCATION: All clinicians and Clinical Manager were in-serviced on the consistent, proper logging of patient medication, their use, and frequency. Implementation of medication reconciliation tracking process. **Who is responsible to implement the corrective action?** Clinical Manager with oversight from Administrator **What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?** Clinical manager will review medication reconciliation documentation for the two weeks post-corrective action implementation to ensure 100% compliance. If the criteria is met, review frequency will decrease to 50% of medication reconciliation documentation for the subsequent two weeks, where 100% compliance will remain the expectation. Thereafter, a monthly audit will be conducted on 10% of medication reconciliation	04/19/2021

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	medications, in accordance with applicable organization policies ... PROCEDURE ... 2. The components of the medication assessment used to determine patient and family/caregiver knowledge and skill related to medication administration will include, but will not be limited to: A. Name, dosage, route, duration, time and usage of medication, intended use as well as expected actions of drug therapy ... K. Other information, as applicable ...." 3. An agency policy, number 8-020, titled "Regulatory Compliance" revised December 2019, stated, "PURPOSE ... To ensure compliance with local, state, federal, and other regulatory bodies... POLICY ... The organization will maintain evidence of regulatory compliance, including but not limited to: ... 12. professional standards and principles ... A. Federal regulations ... B. State practice acts ... C. Commonly accepted health standards established by national organizations, boards and councils.... " 4. Clinical record review on 4/16/2021, for patient #1, start of care 4/9/2021, diagnosis of atrial fibrillation [irregular heartbeat when the upper and lower chambers beat out of order], evidenced a document titled "Home Health Certification and Plan of Care" for certification period 4/9/2021 - 6/7/2021. This document had an area subtitled "Medications" which stated "Glipizide [anti-diabetic medication] ... Losartan [anti-hypertensive medication] ... and Simvistatin [used to treat high cholesterol] ...." Record review of the medical plan of care evidenced the patient was taking 3 medications. Record review evidenced an agency document titled "Visit Note Report" from 4/9/2021, which was signed by RN [registered nurse] D. This		documentation to ensure continued compliance. Any discrepancy within the clinician documentation will result in re-education to the clinical staff in accordance with the corrective action above.	

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	document had an area subtitled "Narrative" which stated "Patient reports no pain but takes Tylenol [Non-Steroidal Anti-Inflammatory Drug]...." Record review failed to evidence "Tylenol" was listed under "Medications" on the medical plan of care. Record review failed to evidence the plan of care was individualized to include all medications and indications for which they were being used by the patient. 5. Clinical record review on 4/16/2021, for patient #2, start of care 8/12/2020, primary diagnosis of multiple sclerosis, evidenced an agency document titled, "Home Health Certification and Plan of Care" for certification period 12/10/2020 - 2/7/2021. This document had an area subtitled "Medications" which stated "Hydrocodone [opioid pain medicine] 5 MG [milligrams]-Acetaminophen [generic name for Tylenol] 325 MG Tablet Oral ... 1 tablet Every 8 Hours/PRN [as needed] ... Instructions: For Up To 7 Days ... Lactulose [laxative] 20 Gram/30 ML [milliliter] Oral Solution ... 30 mL 2 Times Daily/PRN ... Oxycodone [opioid pain medication] 5 MG Tablet ... Every 6 Hours/PRN ... Instructions: For up to 7 Days ... Zolpidem [sleep aid medication] 10 MG Tablet ... Bedtime/PRN ...." This document had an area subtitled "Orders of Discipline and Treatments" which stated, "Skilled nurse to assess evaluate co-morbid conditions including hypotension, hypothyroidism, and other conditions that present themselves during the course of this episode to identify changes and intervene to minimize complications ... Skilled nurse to perform observation/assessment of genitourinary status and intervene to minimize complications of disease process. Skilled nurse to provide instruction regarding management of disease process including pathophysiology, nutritional/fluid requirements, and medication			

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	regimen ... 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 document was signed by the patient's physician on 12/18/2020. Record review failed to evidence all PRN medications on the medical plan of care were individualized to include specific indications for which they were prescribed. Record review evidenced an agency document titled "Client Coordination Note Report" which had an area that stated "Note Type ... CLINICAL." The document stated "PT [patient] flushed with white mucus present in urine in Foley bag. [Person D, infectious disease doctor]'s office notified ...." This note was entered by RN C on 12/22/2020. Record review evidenced mucus in the patient's urine, which is an indication of an infection. Record review failed to evidence Person D as the primary physician to be notified. Record review evidenced an agency document titled "Client Coordination Note Report" which had an area that stated "Note Type ... CLINICAL." The document stated "Spoke with [Person A] on 12.24.20. [Person A] requested nurse for a visit to assess patient. After speaking with the nurse, and receiving an update on the patient's status from the caregiver; I recommended the patient's status required further evaluation from a MD [Doctor of Medicine]. [Person A] refused. The nurse on the case spoke with [Person C] and [they] agreed that the patient warranted further assessment and needed to go to the Emergency Room ... After I explained the MD's recommendation [they] stated [they] would not be taking [patient #2] to the Emergency Room and hung up. Writer attempted to call [Person A]			

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	back; however, unsuccessful in reaching patient on second attempt.... " This note was entered by former employee B, on 12/25/2020. Record review evidenced an agency document titled "Client Coordination Note Report" which had an area that stated "Note Type ... CLINICAL." The document stated "RN received message from caregiver and [Person A] that Foley has low output and bulge present to pelvic region. PT and caregiver advised to go to ED [Emergency Department] ... PT refused. [Person C] paged. Per MD, PT to go to ED. CM [case manager] notified of above. Per CM, contacted [Person A] to notify of MD orders, [Person A] refused and stated, "I will take care of it." RN received message from caregiver that [patient's family member] had exchanged Foley catheter. This document 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 an on call skilled nurse assessed the patients new onset condition as ordered in the plan of care. 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; 4 days later. The administrator indicated the nurse was following the doctor's orders. During an interview on 4/16/2021, at 11:07 AM, the administrator indicated the agency could have sent the on call nurse to "lay eyes" on the patient and help to get the patient ready for the emergency department.			

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	6. Clinical record review on 4/16/2021, for patient #3, start of care 10/1/2020, primary diagnosis of liver transplant, evidenced an agency document titled, "Home Health Certification and Plan of Care" for certification period 10/1/2020 - 11/29/2020. This document had an area subtitled "Medications" which stated "Acetaminophen 325 MG ... 2 Tablet Every 6 Hours/PRN ... Norco [opioid pain medicine and Tylenol combination] 10 MG - 325 MG Tablet Oral ... 1 tablet Every 4 Hours/PRN ...." Record review failed to evidence all PRN medications on the medical plan of care were individualized to include specific indications for which they were prescribed. During an interview on 4/16/2021, at 10:39 AM, the Clinical Manager indicated PRN medications should include indications for when they are to be used. 410 IAC 17-13-1(a)			
G 0682 Bldg. 00	484.70(a) Infection Prevention Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, the home health agency failed to ensure all employees used standard precautions to prevent the transmission of infections and communicable diseases for 1 of 1 home visits. (employee D) The findings include:	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 policies and procedures. They will also receive one on one field-based	04/19/2021

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	An agency policy, number 7-001, titled "Infection Control Plan" revised December 2019, stated "PURPOSE ... To delineate an infection control plan to meet the following goals: ... 2. Guide organization personnel in the care and services they provide in relation to infection control practices ... 5. Comply with all applicable local, state, and federal regulations, including, but not limited to: A. State and federal OSHA [Occupational Safety and Health Administration] mandates ... B. CDC [Center for Disease and Control] recommendations and guidelines ... POLICY ... HRS Home Health of Indiana LLC is committed to reducing the risk of acquisition and transmission of health care associated infections (HAIs). recognized prevention in control mechanisms will be implemented for planning, surveillance, identification, prevention controls, and reporting procedures ... Definitions ... The following definitions describe terms used by HRS Home Health of Indiana LLC throughout this section ... 11. Decontamination: The use of physical or chemical means to remove, inactivate, or destroy blood borne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles, and the surface or item is rendered safe for handling, use, or disposal ... 15. Hand Hygiene: A general term that applies to either hand washing, antiseptic hand wash, antiseptic hand rub, or surgical hand antisepsis ... 24. Personal Protective Equipment (PPE): Specialized clothing or equipment worn by personnel for protection against a hazard ... 30. Standard Precautions: An approach to infection control where all human blood and certain human body fluids are treated as if known to be infectious for HIV [human immunodeficiency virus], HBV [hepatitis B virus], and other blood borne pathogens ... PROCEDURE ... 1. HRS Home Health of Indiana LLC will educate all personnel		education via their preceptor and Lead RN; which will include infection control scenarios during in-home visits. Lead RN will also perform quarterly joint visits and competency will be assessed based on the “Performance Observation Report” as it pertains to Infection Control. **Who is responsible to implement the corrective action?** Administrator **What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?** Lead RN will perform joint visits to 25% of clinician staff on a quarterly basis to ensure compliance with the HRS Infection Control policy and procedure and the organization’s Continuous Quality Improvement program. During each joint visit, competency will be assessed based on the “Performance Observation Report” as it pertains to Infection Control. The clinician will be evaluated on the 11 items outlined in the “Performance Area” and must receive a passing score of at least 90%. Administrator will perform an audit within 30 days of implementation to show a 100% pass rate of infection prevention and control	

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	on infection control policies, procedures, and their responsibilities for implementation as contained throughout this section. New personnel will receive a copy of the standard precautions (see "Standard Precautions" policy No. 7-007) in their orientation packets ... 2. Personnel will be provided training on the basics of transmission of pathogens to patients and personnel, blood borne diseases, the use of standard precautions, infectious waste management, and other infection control procedures...." An agency policy, number 7-007, titled "Standard Precautions" revised December 2019, stated "PURPOSE ... To reduce the risk of exposure to and transmission of infections when caring for patients ... POLICY ... Organization personnel will adhere to the following precautions and will instruct patients and family caregivers in infection control precautions, as appropriate to the patients care needs ... PROCEDURE: ... General Precautions ... Hand Hygiene ... 1. Hand hygiene will be performed to prevent cross contamination between the patient and personnel (see also "Hand Hygiene " Policy No. 7-009.) ... Personal protective equipment ... 1. Gloves: A. ... Gloves are to be worn when: ... 3. Touching contaminated items or surfaces ... 5. Handling any drainage appliance ... 10. Cleaning of body fluids and decontamination procedures ... C. Gloves are to be changed: ... 1. Between tasks and procedures on the same patient ...." An agency policy, number 7-009, titled "Hand Hygiene" revised December 2019, stated "PURPOSE ... To prevent cross-contamination and homecare acquired infections ... POLICY ... Personnel providing care in the home setting will regularly wash their hands, per the most recently published CDC regulations and guidelines for		policies and procedures. If the clinician does not pass, they will receive a Coaching Note from the Lead RN, must repeat the coursework under the supervision of the Lead RN/Administrator, and must repeat the joint visit. This monitoring will be a permanent part of quarterly Continuous Performance Improvement.	

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	157436	A. BUILDING 00 B. WING	04/19/2021

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	hand hygiene in healthcare settings ... PROCEDURE ... Hand decontamination with an alcohol-based hand rub ... 3. Hand decontamination using an alcohol-based hand rub should be performed: ... A. Before Having direct contact with patients ... C. After contact with a patient's intact skin (when taking a pulse, blood pressure or lifting a patient) ... F. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient ... G. After removing gloves ...." An agency policy, number 7-016, titled "Bag Technique" revised December 2019, stated "PURPOSE ... To describe the procedure for maintaining a clean nursing bag/computer bag and preventing cross-contamination ... POLICY ... As part of the infection/exposure control plan, HRS Home Health of Indiana LLC personnel will consistently implement principles to maximize efficient use of the patients care supply bag when used in caring for patients ... PROCEDURE ... Bag Technique ... 3. After hand washing, the supplies and/or equipment needed for the visit will be removed from the bag ... 5. When the visit is completed, reusable equipment will be cleaned using alcohol, soap and water, or other appropriate solution, hands will be washed, and equipment and supplies will be returned to the bag ... 6. Hands will be decontaminated prior to returning clean equipment to bag ...." During an observation on 4/16/2021, at 2:00 PM, of a home visit for patient #1, start of care 4/9/2021, diagnosis of Atrial Fibrillation (irregular heartbeat, often rapid and causes poor blood flow), RN D entered the patient's home as instructed by the patient via telephone. At 2:06 PM, RN D, placed a barrier on the patient's couch,			

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	applied alcohol-based hand rub (ABHR), placed tablet and work bag on top of barrier, and then applied gloves. RN D went into their work bag to obtain a thermometer, blood pressure cuff, and pulse oximeter. The patient could not find their home folder supplied by the agency and RN D began to help the patient by looking underneath cluttered items and in bedrooms. According to the agency policy 7-009, RN D should have changed gloves and sanitized after touching inanimate objects. At 2:10 PM, 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. RN D placed the tablet on the barrier and picked up their stethoscope. The nurse placed the stethoscope to the patient's chest, then to the patient's stomach. RN D placed stethoscope on the barrier and picked up the tablet to document. According to policy 7-007, RN D should have performed hand hygiene in between performing tasks on the same patient. At 2:30 PM, RN D removed sanitizer wipes from work bag and began to wipe down pulse oximeter, thermometer, blood pressure cuff, and stethoscope, then placed the sanitized equipment in a plastic bag. RN D placed the plastic bag into the work bag, removed their gloves and sanitized hands with ABHR. Observation failed to evidence RN D changed gloves after patient contact, between performing tasks on the same patient, after touching inanimate objects, decontaminating reusable equipment, and prior to returning decontaminated items into the work bag. On 4/16/2021, at 3:57 PM, the administrator and clinical manager were notified of the observations during the home visit for patient #1.			

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	410 IAC 17-12-1(m)			
N 0000 Bldg. 00	State complaint investigation survey was conducted at HRS Home Health of IN LLC by the Indiana Department of Health in accordance with 410 IAC 17. Complaint # IN00345294 - substantiated with findings Survey Dates: 4/14/2021, 4/15/2021, 4/16/2021 Facility ID: 157436 At this State survey, HRS Home Health of IN LLC was found to not be in compliance with 410 IAC 17.	N 0000	Per direction above, no action required	
N 0488 Bldg. 00	410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services			

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	to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (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. Based on record review, the home health agency failed to develop and implement a 15-day discharge policy. The findings include: An agency policy, number 9-005, titled "Bill of Rights" revised December 2019, stated "PURPOSE ... To encourage awareness of patient rates and provide guidelines to assist patients in making decisions regarding care and for active participation in planning ... POLICY ... Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights in responsibilities as described ... PROCEDURE ... 2. The patient Bill of Rights statement defines the right of the patient to: ... 2. ... AA. The organization's transfer and discharge policies ...." On page 12 of the agency's sample admission book, evidenced a policy titled "HRS HOME HEALTH DISCHARGE CRITERIA" which stated "1. Services will be terminated when the patient	N 0488	**What action will we take to correct the deficiency cited?** EDUCATION: All clinicians were in-serviced on the Indiana state 15-day Discharge Policy. POLICY UPDATE: Agency Policy and Procedure manual has been updated as of April 19th to include the 15-day discharge notification. PATIENT INFORMATION PACKET: Discharge policy and procedure were updated and added within the Patient Bill of Rights. **Who is responsible to implement the corrective action?** Administrator **What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?**	04/19/2021

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	meets one (1) or more of the discharge criteria ... A. A change in the patient's medical or treatment program that requires a change to a different level of care ... B. A change in the patient's condition requires care or services other than that provided by the organization. If the patient acuity requires another level of care that the organization cannot provide, the organization shall arrange for a safe and appropriate transfer to another organization that can provide the needed level of care ... D. The patient or family/caregiver riff uses, discontinues care, or elects to transfer to another ... E. The patient or family/caregiver refuses to cooperate in attaining the objectives of home care ... G. The patient and/or family display disruptive, abusive, and uncooperative behavior ... PROCEDURE ... 4. For a patient requiring continuing care, assistance will be given to the patient and family/caregiver in order to manage continuing care needs after the organization services are discontinued ... 5. The decision to terminate or reduce services must be documented in the clinical record citing the circumstances in notification to the patient, the responsible family/caregiver or representative, and the patient's position. Efforts to resolve problems prior to discharge will also be documented in the patients record. The patient will be provided contact information for other home health agencies and providers if continued care is needed. The clinical supervisor or designee is accountable for the decision and the required documentation. If the decision to terminate services is due to the patient's behavior, the behavior of other persons in the home, or situation, the clinical record must reflect the following: A. identification of the problems encountered ... B. assessment of the situation ... C. communication with the organization management and the physician responsible for the		Agency performs 100% weekly audit of patient Bill of Rights and consent forms, which acknowledges receipt of patient education for agency DC policy and procedure including the 15-day notification requirement.	

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	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.			