

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>157536</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>04/08/2022</b>
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NAME OF PROVIDER OR SUPPLIER <b>METHODIST HOME CARE SERVICES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>303 E 89TH AVENUE, SUITE A, ROOM 117 , MERRILLVILLE, Indiana, 46410</b>
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E0000	Initial Comments  An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Survey Dates: 4/5/2022, 4/6/2022, 4/7/2022, and 4/8/2022 Census: 891 - Active At this Emergency Preparedness survey, Methodist Home Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000		
E0017	HHA Comprehensive Assessment in Disaster  CFR(s): 484.102(b)(1)  §484.102(b)(1) Condition for Participation:  [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.  At a minimum, the policies and procedures must address the following:]  (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55.  This STANDARD is NOT MET as evidenced by:  Based on observation, record review, and interview, the home health agency failed to ensure all clinicians created an individualized emergency preparedness plan with each patient, to include but not limited to relocation and shelter information for 4 of 8 clinical records reviewed. (#1, #2, #3, #4)The findings include:	E0017		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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E0017	Continued from page 1  1. Record review of an agency policy titled, "Emergency Management Plan" revised June 2021, stated "I. Policy: Prepare for and manage and emergency and restore to the same operational capabilities as pre-emergency levels. To ensure that adequate patient services and staff safety are provided when emergency conditions do not allow normal access to or from patient's home ... Phase One – Mitigation: ... Disasters may include but not limited to: ... e. Communication outage ... g. Computer services unavailable for clinical or office system ... Phase Three – Response: Implementation of the Emergency Management Plan by management and response to the Emergency Management Plan by all staff ... 1) Command Structure: The Emergency Management Plan will be implemented upon the direction of the Command Center ... Every employee is given an updated copy of the Emergency Command Structure if changes are applied and a current copy is kept in the On-call Binder ... Case managers or their designees are responsible for patient triage. They will review patient caseloads with clinical staff and establish visit priorities based on patient priority level 1, 2, 3, and four. Patients will be seen by staff as soon as the emergency is over or it is safe to do so. A list of active patients and employees will be printed and distributed to administrative staff as needed for reference ... 5) Patients will be given emergency preparedness instructions upon home health admission and will be assured they will not be abandoned during an emergency ... Emergency instructions given to a patient/ caregiver will be documented in the medical record. If patient needs to leave/ evacuate their home they are to call the Methodist home care office as soon as possible with their new location ... 6) During and emergency event supervisory and/ or field staff will contact active patients to evaluate and assist within the patient arrangements concerning evacuation plans, if any ...."2. An observation of a home visit was conducted on 4/7/2022, at 9:30 AM, for patient #1, start of care 5/11/2021, the patient's home folder which contained information provided by the home health agency, was reviewed for required information. Review of the home folder failed to evidence an individualized emergency preparedness plan to include specific relocation information. Clinical record review on 4/8/2022, evidenced an agency document titled "SN [Skilled Nurse] OASIS [Outcome and Assessment Information Set] Recertification" electronically signed by RN	E0017		

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E0017	Continued from page 2 [Registered Nurse] D on 3/3/2022. This document had an area subtitled "Emergency Preparedness Plan" that stated "The most common emergency situations for our area are weather related events that close roads or result in power outages. It is important to plan for these events in advance. Address all applicable statements below: ... 3. Where is the safest place in your home?: Bathroom ... 4. Where will you go if you need to leave your home?: Relative's home ... 8. If a power outage last longer than 24 hours, how will you plan to handle?: Go to another home or location ...." Review failed to evidence specific emergency preparedness information to include but not limited to specific relocation and/or shelter information. During an interview on 4/7/2022, at 10:19 AM, patient #1 indicated no one from Methodist Home Care has discussed an individualized emergency preparedness plan. Patient #1 and live in caregiver indicated they were unsure of the nearest shelter or where to go if they could not stay in the home. 3. Clinical record review on 4/8/2022, for patient #2, start of care 7/31/2021, evidenced an agency document titled "SN OASIS Recertification" electronically signed by RN D on 3/26/2022. This document had an area subtitled "Emergency Preparedness Plan" that stated "The most common emergency situations for our area are weather related events that close roads or result in power outages. It is important to plan for these events in advance. Address all applicable statements below: ... 3. Where is the safest place in your home?: Bathroom ... 4. Where will you go if you need to leave your home?: Relative's home ... 8. If a power outage last longer than 24 hours, how will you plan to handle?: Go to another home or location ...." Review failed to evidence specific emergency preparedness information to include but not limited to specific relocation and/or shelter information. 4. Clinical record review on 4/8/2022, for patient #3, start of care 3/6/2022 evidenced an agency document titled "SN OASIS Start of Care" electronically signed by RN L on 3/6/2022. This document had an area subtitled "Emergency Preparedness Plan" that stated "The most common emergency situations for our area are weather related events that close roads or result in power outages. It is important to plan for these events in advance. Address all applicable statements below: ... 3. Where is the safest place in your home?: Bathroom ... 8. If a power outage last longer than 24 hours, how will you plan to handle?: Go to another home or location ...." Review failed to evidence specific	E0017		

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E0017	Continued from page 3 emergency preparedness information to include but not limited to specific relocation and/or shelter information.5. Clinical record review on 4/8/2022, for patient #4 start of care 3/18/22, evidenced an agency document titled "SN OASIS Start of Care" electronically signed by physical therapist (PT) K on 3/18/2022. This document had an area subtitled "Emergency Preparedness Plan" that stated "The most common emergency situations for our area are weather related events that close roads or result in power outages. It is important to plan for these events in advance. Address all applicable statements below: ... 3. Where is the safest place in your home?: Bathroom ... 4. Where will you go if you need to leave your home?: Relative's home ... 8. If a power outage last longer than 24 hours, how will you plan to handle?: Go to another home or location ...." Review failed to evidence specific emergency preparedness information to include but not limited to specific relocation and/or shelter information.6. During an interview on 4/8/2022, at 11:11 AM, administrator A indicated the patient's emergency preparedness was discussed at the start of care assessment to create a detailed plan. Administrator A indicated the answer to the questions regarding emergency preparedness should be different for each patient.7. During an interview on 4/8/2022, at 11:33 AM, administrator A indicated the answers to questions #3, #4, and #8 were repetitive and not specific to the patient.	E0017		
G0000	INITIAL COMMENTS  This visit was for a Post Condition Revisit survey for Methodist Home Care.Survey Dates: 4/5/2022, 4/6/2022, 4/7/2022, and 4/8/2022.Census: 891 - ActiveDuring this survey, Conditions of Participation 42 CFR 484.60 Discharge Planning was found to be in compliance and 14 standard citations were found to be corrected.Based on the Condition-level deficiencies during the survey conducted on 1/27/2022, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning 1/27/2022 and continuing through 1/26/2024.This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State	G0000		

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G0000	Continued from page 4 Findings.	G0000		
G0436	<p>Receive all services in plan of care</p> <p>CFR(s): 484.50(c)(5)</p> <p>Receive all services outlined in the plan of care.</p> <p>This ELEMENT is NOT MET as evidenced by:</p> <p>Based on record review and interview, the home health agency failed to ensure patients received all services outlined in the plan of care in 1 of 4 active clinical records reviewed. (#2)The findings include:</p> <p>Record review evidenced an agency policy obtained 4/8/2022, titled "Plan of Care," revised 8/2021, which stated, "... Every patient must have a written Plan of Care. This plan must be designed to meet the needs of the patient. The Plan of Care is developed from the physician's orders and is developed and maintained by home care staff in consultation with the physician ...The patient will be informed in advance of any changes in the Plan of Care before the change is made. The patient has the right to participate in planning the care or treatment in advance of such care. ... Staff providing services under arrangement or contract must participate in the development of the Plan of Care, deliver services according to the Plan, and notify the physician of any changes in the patient's condition, per home care policy...." Record review evidenced an agency policy obtained 4/8/2022, titled "Patient Rights and Responsibilities," revised 8/2021, which stated, "...Rights of patients are defined in detail ... which are given to the patient and include: ...Information regarding Plan of Treatment as authorized by the physician, opportunity to participate in developing the Plan, the right to refuse treatment, and the right to make informed decisions regarding care. ... Notice of the disciplines that will be providing services and the proposed frequency of visits. ... Any changes in the care to be furnished ...."Clinical record review on 4/8/2022, for patient #2, start of care 7/31/2021, primary diagnosis change or removal of a surgical wound dressing, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/27/2022 - 3/27/2022, and electronically signed by the patient's physician on 1/26/2022. This document had an area subtitled "21. Orders for Discipline</p>	G0436		

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G0436	Continued from page 5 and Treatments (Specify Amount/Frequency/Duration)" which stated "... SN [skilled nurse] ... 1/27/2022 to 1/29/2022: 1 visit every week for 1 week ... 1/30/2022 to 3/26/2022: 3 visits every week for 8 weeks ...."Record review of agency documents from the week of 3/6/2022 – 3/12/2022, titled "SN Home Visit" evidenced SN visits were conducted on 3/9/2022. Review failed to evidence missed visit documentation for the week 3/6/2022 – 3/12/2022. Review failed to evidence SN visits were conducted three times a week from 1/30/2022 – 3/26/2022. Review failed to evidence physician notification for the missed visits. Review failed to evidence the services were provided as ordered in the plan of care. During an interview on 4/5/2022, at 11:24 AM, administrator A indicated missed visit notes should be documented in the same section of the visit frequencies in the electronic medical record.	G0436		
G0572	Plan of care  CFR(s): 484.60(a)(1)  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 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.  This STANDARD is NOT MET as evidenced by:  Based on record review, the home health agency failed to ensure the plan of care's frequency and duration was followed by every discipline as ordered by the physician in 1 of 3 discharged records reviewed with skilled nursing services. (#7)  The findings include:  Record review evidenced an agency policy obtained 4/8/2022, titled "Plan of Care," revised 8/2021, which stated, "Policy: ... To establish guidelines that promotes appropriate care planning to ensure	G0572		

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G0572	Continued from page 6 acceptable delivery of care ... A. Every patient must have a written Plan of Care. This plan must be designed to meet the needs of the patient. The Plan of Care is developed from the physician's orders and is developed and maintained by home care staff in consultation with the physician. ...The patient will be informed in advance of any changes in the Plan of Care before the change is made. The patient has the right to participate in planning the care or treatment in advance of such care...." Clinical record review on 4/6/2022, for patient #7, start of care 2/26/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 2/26/2022 - 4/26/2022. This document had a subsection titled, "Orders for Discipline and Treatments," which stated, "... SN [skilled nurse] ... 2/26/2022 to 2/26/2022: 1 visit every week for 1 week, 2/27/2022 to 3/19/2022: 2 visits every week for 3 weeks...." Clinical record review evidenced agency documents titled, "OASIS [Outcome and Assessment Information Set] Start of Care," "SN [skilled nurse] Home Visit," and "Discipline Discharge," which evidenced skilled nurse visits were conducted on 2/26/2022, 3/4/2022, 3/8/2022, 3/10/2022, and 3/16/2022. Clinical review evidenced missed visit documentation for a visit on 3/2/2022 but did not evidence rescheduling of that visit. Review failed to evidence SN visits were conducted twice a week for 3 weeks, as ordered by the physician on the plan of care. Clinical record review evidenced agency documents titled, "SN Home Visit" dated 3/2/2022, 3/8/2022, and 3/10/2022. These documents had a subsection titled, "Teaching Assessment," which stated, "...Willing and accepting of necessary care: Yes; Desires and is motivated to learn: Yes; Understands importance/benefits/risks of care: Yes; Understands consequences of not performing care: Yes...." At 4/8/2022 at 1:05 PM, the administrator was informed of this concern.  410 IAC 17-13-1(a)	G0572		
G0574	Plan of care must include the following  CFR(s): 484.60(a)(2)(i-xvi)  The individualized plan of care must include the following:  (i) All pertinent diagnoses;  (ii) The patient's mental, psychosocial, and	G0574		

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G0574	<p>Continued from page 7 cognitive status;</p> <p>(iii) The types of services, supplies, and equipment required;</p> <p>(iv) The frequency and duration of visits to be made;</p> <p>(v) Prognosis;</p> <p>(vi) Rehabilitation potential;</p> <p>(vii) Functional limitations;</p> <p>(viii) Activities permitted;</p> <p>(ix) Nutritional requirements;</p> <p>(x) All medications and treatments;</p> <p>(xi) Safety measures to protect against injury;</p> <p>(xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.</p> <p>(xiii) Patient and caregiver education and training to facilitate timely discharge;</p> <p>(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;</p> <p>(xv) Information related to any advanced directives; and</p> <p>(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.</p> <p>This ELEMENT is NOT MET as evidenced by:</p> <p>Based on record review and interview, the agency failed to ensure the individualized plan of care included patient-specific interventions in accordance with known diagnoses for 5 of 8 clinical records reviewed. (#1, #3, #4, #6, #7)The findings include:</p> <p>1. Review of an agency policy obtained 4/8/2022, revised 8/2021, titled "Plan of Care" stated, "...The Plan of Care is developed from the physician's orders, and is developed and maintained by home care staff in consultation with</p>	G0574		

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G0574	Continued from page 8 the physician. ... The Plan of Care must include the type of services to be provided and the frequency and duration of these services, including: 1) Disciplines and frequency & duration of visits, 2) Specific procedures & treatments, including frequency & duration, 3) Specific modalities & amount of therapy services, 4) PRN (as needed) visits with a specified number and reason, ... 14) Any safety measures to protect against injury...”2. Clinical record review on 4/6/2022 for patient #6, start of care 2/17/2022, diagnoses including but not limited to malignant neoplasm of the prostate (prostate cancer) and essential hypertension (abnormally high blood pressure) evidenced an agency document titled, “Home Health Certification and Plan of Care” for certification period 2/17/2022 – 4/17/2022. Review of this document failed to evidence orders to assess patient vital signs at each visit in accordance with all known diagnoses. Review failed to evidence the plan of care included orders individualized to the patient's needs.3. Clinical record review on 4/6/2022 for patient #7, start of care 2/26/2022, diagnoses including but not limited to hypotension (abnormally low blood pressure) and essential hypertension (abnormally high blood pressure) evidenced an agency document titled, “Home Health Certification and Plan of Care” for certification period 2/26/2022 – 4/26/2022. Review of this document failed to evidence orders to assess patient vital signs at each visit in accordance with all known diagnoses. Review failed to evidence the plan of care included orders individualized to the patient's needs.4. Clinical record review on 4/8/2022, for patient #1, start of care 5/11/2022, diagnoses include but not limited to paraplegia (paralysis of the lower body due to spinal injury) and essential hypertension (abnormally high blood pressure), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 3/7/2022 - 5/5/2022, and electronically signed by the physician on 3/31/2022. Review of this document failed to evidence orders to assess vital signs. Review failed to evidence the plan of care included orders individualized to the patient's needs.5. Clinical record review on 4/8/2022, for patient #3, start of care 3/6/2022, diagnoses included but not limited to Lymphedema (a condition caused by a blockage in the immune and circulatory systems) and hypertension, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 3/6/2022 - 5/4/2022, and electronically	G0574		

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G0574	Continued from page 9 signed by the physician on 3/21/2022. Review of this document failed to evidence orders to assess vital signs. Review failed to evidence the plan of care included orders individualized to the patient's needs. 6. Clinical record review on 4/8/2022, for patient #4, start of care 3/18/2022, diagnoses included but not limited to hypertension and type 2 diabetes with hyperglycemia (elevated blood sugar levels), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 3/18/2022 - 5/16/2022. Review of this document failed to evidence orders to assess vital signs. Review failed to evidence the plan of care included orders individualized to the patient's needs. 7. During an interview on 4/8/2022 at 11:15 AM, when queried as to how a clinician would know to report abnormal vital signs, Administrator A indicated a blood pressure of 140/90 [120/80 is considered to be a normal blood pressure] was the suggested threshold in a recent discussion. Administrator A also indicated if the patient had a high blood pressure and was also on blood pressure medication, the clinician should notify the physician.410 IAC 17-13-1(a)(1)(D)(i-xiii)	G0574		
G0580	Only as ordered by a physician  CFR(s): 484.60(b)(1)  Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner.  This ELEMENT is NOT MET as evidenced by:  Based on observation, record review, and interview, the agency failed to ensure treatment was administered only as ordered by a physician in 1 of 3 clinical records reviewed with a home visit. (#5)  The findings include:  Review of an agency policy obtained 4/8/2022, revised 8/2021, titled, "Physician Orders," stated, "...Policy: To ensure that physicians will provide orders for services within accepted standards of care. ... Treatments and medications are to be administered by staff only as physician ordered..."Clinical record review on 4/7/2022 for patient #5, start of care 11/27/2021, for certification period 3/27/2022 to 5/25/2022, evidenced an agency document titled, "Home Health	G0580		

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NAME OF PROVIDER OR SUPPLIER <b>METHODIST HOME CARE SERVICES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>303 E 89TH AVENUE, SUITE A, ROOM 117 , MERRILLVILLE, Indiana, 46410</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0580	Continued from page 10 Certification and Plan of Care." This document had a subsection titled, "Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)," which stated, "...Wound Care Therapy [Wound care to promote healing] HH [home health] WOUND CARE – (GENERAL) [Each Visit, Start: 2/18/2022] [Instruct Patient and Caregiver in wound care. Wound care to consist of Cleanse right breast with, saline. Apply SSD [silver sulfadiazine - a topical antibiotic used to treat burns] 1% cream to wound bed, cover with dry dressing and secure with tape, change three times weekly and PRN [as needed] for soilage.] Perform wound care [Each Visit, Start: 3/14/2022] [Instruct Patient and Caregiver in wound care. Wound care to consist of Cleanse left breast with, saline. Apply adaptic [dressing made of knitted cellulose acetate fabric and impregnated with a specially formulated petrolatum emulsion] covered by polymem [a hydrophilic polyurethane matrix dressing with a mild, non-toxic wound cleanser, a soothing moisturizer, a superabsorbent and a semi-permeable film backing]. Cover with dry dressing and secure with tape, change three times weekly and PRN for soilage.]Clinical record review evidenced an agency document titled, "OASIS [Outcome and Assessment Information Set] Recertification," digitally signed by RN [registered nurse] D and dated 3/23/2022. This document had a subsection titled, "LDA [lines, drains, airways] and Wound Assessment," which stated, "... Burn Breast Right...3/23/22... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorbant [sic] pad; Elastic bandage; Other (Comment) adaptic and polymem ... Breast Left ... 3/23/22 ... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorbant [sic] pad; Elastic bandage; Other (Comment) adaptic and polymem...." The document failed to evidence the RN administered treatment as ordered by a physician.Clinical record review evidenced an agency document titled, "SN [skilled nurse] – Home Visit," digitally signed by RN J and dated 3/24/2022. This document had a subsection titled, "LDA and Wound Assessment," which stated, "...Burn Breast Right ... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorbant [sic] pad; Dry dressing; Non adherent polymem ... Breast Left ... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorbant [sic] pad; Non adherent polymem...." The document failed to evidence the RN administered treatment as ordered by a physician.Clinical record review evidenced an agency document titled, "SN – Home Visit," digitally signed by RN D and dated 3/26/2022. This	G0580		

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G0580	Continued from page 11 document had a subsection titled, "LDA and Wound Assessment," which stated, "Burn Breast Right...3/26/22... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorbant [sic] pad; Non adherent Other (Comment) polymem ... Breast Left ... 3/26/22 ... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorbant [sic] pad; Non adherent; Other (Comment) polymem...." The document failed to evidence the RN administered treatment as ordered by a physician.Clinical record review evidenced an agency document titled, "SN – Home Visit," digitally signed by RN D and dated 3/28/2022. This document had a subsection titled, "LDA and Wound Assessment," which stated, "Burn Breast Right...3/28/22... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorbant [sic] pad; Non adherent Other (Comment) polymem ... Breast Left ... 3/28/22 ... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorbant [sic] pad; Non adherent; Other (Comment) polymem...." The document failed to evidence the RN administered treatment as ordered by a physician.Clinical record review evidenced an agency document titled, "SN – Home Visit," digitally signed by RN D and dated 3/30/2022. This document had a subsection titled, "LDA and Wound Assessment," which stated, "Burn Breast Right...3/30/22... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorbant [sic] pad; Non adherent Other (Comment) polymem ... Breast Left ... 3/30/22 ... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorbant [sic] pad; Non adherent; Other (Comment) polymem...." The document failed to evidence the RN administered treatment as ordered by a physician.Clinical record review evidenced an agency document titled, "SN – Home Visit," digitally signed by RN D and dated 4/1/2022. This document had a subsection titled, "LDA and Wound Assessment," which stated, "Burn Breast Right...4/1/22... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorbant [sic] pad; Non adherent Other (Comment) polymem ... Breast Left ... 4/1/22 ... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorbant [sic] pad; Non adherent; Other (Comment) polymem...." The document failed to evidence the RN administered treatment as ordered by a physician.Clinical record review evidenced an agency document titled, "SN – Home Visit," digitally signed by RN H and dated 4/4/2022. This document had a subsection titled, "LDA and Wound Assessment," which stated, "Burn Breast Right...4/4/22... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorbant [sic] pad; Non adherent Other (Comment) polymem ... Breast Left ... 4/4/22 ... Wound Cleansing: Normal Saline,	G0580		

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G0580	Continued from page 12 Dressing/Treatment: Absorband [sic] pad; Non adherent; ...." The document failed to evidence the RN administered treatment as ordered by a physician.Clinical record review evidenced an agency document titled, "SN – Home Visit," digitally signed by RN D and dated 4/6/2022. This document had a subsection titled, "LDA and Wound Assessment," which stated, "Burn Breast Right...4/6/22... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorband [sic] pad; Non adherent Other (Comment) polymem ... Breast Left ... 4/6/22 ... Wound Cleansing: Normal Saline, Dressing/Treatment: Absorband [sic] pad; Non adherent; Other (Comment) polymem...." The document failed to evidence the RN administered treatment as ordered by a physician.Clinical record review evidenced an agency document titled, "SN – Missed Visit Documentation," signed by RN D and dated 3/25/2022, which stated, "...Patient is going to wound clinic today...." Further review failed to evidence new orders from the wound clinic.Clinical record review evidenced an agency document titled, "Revised Intervention," entered and digitally signed by RN D on 4/6/2022 at 10:27 AM, which stated, "...Wound care to consist of Cleanse left breast with, saline. Apply adaptic covered by polymem. Cover with dry dressing and secure with tape or elastic bandage, change three times weekly and PRN for soilage...." The RN failed to administer treatment as ordered by the physician.Clinical record review evidenced an agency document titled, "Revised Intervention," entered and digitally signed by RN D on 4/6/2022 at 5:42 PM, which stated, "...Wound care to consist of Cleanse right breast with, saline. Apply adaptic covered by polymem. Cover with dry dressing and secure with tape or elastic bandage, change three times weekly and PRN for soilage...." The RN failed to administer treatment as ordered by the physician.During an observation of care on 4/6/2022 at 1:00 PM, RN D was observed cleansing the wounds on patient #5's right and left breasts with gauze and normal saline. She then placed adaptic dressing to the wound on the right breast, then polymem, and a dry absorbent dressing over it. On the left breast, she placed adaptic and a dry absorbent dressing over it. The RN was observed applying a treatment not ordered by the physician. During an interview on 4/8/2022 at 11:21 AM, administrator A indicated that if a patient goes to the wound clinic, the nurse will find the wound clinic orders in the home or the wound clinic will fax the orders to the agency, then the information would be submitted into the patient's Plan of Care and	G0580		

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G0580	Continued from page 13 updated in the patient's chart. When queried as to where the orders from the wound clinic would be found, administrator A indicated the wound clinic "is terrible about faxing the orders" but she would have clinical manager B find them.  410 IAC 17-13-1(a)	G0580		
G0590	Promptly alert relevant physician of changes  CFR(s): 484.60(c)(1)  The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.  This ELEMENT is NOT MET as evidenced by:  Based on record review and interview, the agency failed to alert the physician to changes in the patient's condition or needs that suggest the plan of care should be altered 1 of 4 active records reviewed. (#2)The findings include:  Review of an agency titled "Plan of Care" revised in August of 2021, stated, "Procedure ... E. the Plan of Care must be reviewed by the clinician and attending physician at least every 60 days and more often if the patient's condition warrants. The clinician will promptly inform the physician of changes in the patient's condition that indicates and alteration in the plan and the physician must agree to any changes in the plan of care ... F. Effectiveness of the Plan of Care will be documented on visit notes at the time each nurse or therapist visits the patient".Clinical record review on 4/8/2022, for patient #2, start of care 7/31/2021, pertinent diagnoses peripheral vascular disease (PVD; slow and progressive circulation disorder) and a chronic, non-pressure foot ulcer, and diabetes, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/27/2022 - 3/27/2022, and electronically signed by the patient's physician on 1/26/2022. Review of this document failed to evidence parameters for normal and/or out of range vital signs to ensure optimal wound healing. Record review evidenced an agency document titled "SN – Home Visit" which was electronically signed by registered nurse (RN) J on 3/23/2022. This document had an are This document had an area subtitled "Vitals" that	G0590		

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G0590	Continued from page 14 stated "... BP [blood pressure]... (!) 160/120 [Normal blood pressure is 120/80](patient reports that [he/she] has yet to take blood pressure meds) ..." Review of this document evidenced the patients diastolic blood pressure was abnormally elevated. Record review failed to evidence the patient blood pressure was reassessed for accuracy. Record review failed to evidence the patient took their blood pressure medication. Record review failed to evidence the RN notified the physician of an assessment that may alter the plan of care. Record review evidenced an agency document titled "SN OASIS [Outcome and Assessment Information Set] Recertification" electronically signed by RN D on 3/26/2022. This document had an area subtitled "Vitals" that stated "... BP ... (!) 138/92 ...." Review of this document evidenced the patients diastolic blood pressure was abnormally elevated. Record review failed to evidence the patient blood pressure was reassessed for accuracy. Record review failed to evidence the RN notified the physician of an assessment that may alter the plan of care. During an interview on 4/8/2022, at 11:24 AM, clinical manager B indicated that blood pressure would have a negative impact on wound healing. Administrator A indicated they would expect to see physician notification. 410 IAC 17-13-1(a)(2)	G0590		
G0614	Visit schedule  CFR(s): 484.60(e)(1)  Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.  This ELEMENT is NOT MET as evidenced by:  Based on observation, record review, and interview, the home health agency failed to ensure every patient was provided with the required written visit schedule consistent with the plan of care for 1 of 3 patients where a home visit was conducted. (#1) The findings include:  Record review of an agency policy titled "Patient Rights & Responsibilities" revised August 2021, stated, "Policy: To inform the patient/ legal representative, in writing, of his/her rights as a patient of Home Care in advance of furnishing care, and ensure Home Care personnel promote and protect the patient's rights while providing service ... A. A written Statement of Rights and	G0614		

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G0614	Continued from page 15 Responsibilities will be given to each patient/representative during the Initial Assessment Visit, which outlines the patient's regarding services performed by Home Care. Patients must be notified in writing of their rights and obligations in advance of furnishing care ... 2) Information regarding Plan of Treatment as authorized by the physician, opportunity to participate in developing the Plan, the right to refuse treatment, the right to make informed decisions about their care ... 6) Notice of the disciplines that will be providing services and proposed frequency of visits ... E. The patient will be supplied with a copy of their current plan of care ... M. Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to: ... The disciplines that will furnish the care ... The frequency of visits ...." An observation of a home visit was conducted on 4/7/2022, at 9:30 AM, for patient #1, start of care 5/11/2021, with home health aide (HHA) F. At 10:15 AM, the home folder was reviewed and failed to evidence a visit written schedule for services provided by Methodist Home Care. Review failed to evidence a visit schedule to include the frequencies of every discipline providing services to the patient. Review failed to evidence the patient had the required written visit schedule in the patient's home. During an interview on 4/7/2022, at 10:20 AM, patient #1 indicated staff has a basic set schedule and will call the day before a visit and adjust times/days as needed.	G0614		
G0616	Patient medication schedule/instructions  CFR(s): 484.60(e)(2)  Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA.  This ELEMENT is NOT MET as evidenced by:  Based on observation and record review, the agency failed to ensure patients written instructions provided to patient's included all medication instructions including medication name, dosage, and frequency of administration for 1 of 3 patients where a home visit was conducted. (#1)The findings include:	G0616		

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G0616	Continued from page 16  Review of an agency policy titled "Patient Rights & Responsibilities" revised August 2021, stated, "Policy: To inform the patient/ legal representative, in writing, of his/her rights as a patient of Home Care in advance of furnishing care, and ensure Home Care personnel promote and protect the patient's rights while providing service ... A. A written Statement of Rights and Responsibilities will be given to each patient/representative during the Initial Assessment Visit, which outlines the patient's regarding services performed by Home Care. Patients must be notified in writing of their rights and obligations in advance of furnishing care ... 2) Information regarding Plan of Treatment as authorized by the physician, opportunity to participate in developing the Plan, the right to refuse treatment, the right to make informed decisions about their care ... E. The patient will be supplied with a copy of their current plan of care ... M. Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to: ...The care to be furnished based on the comprehensive assessment .... " Review of an agency policy obtained 1/26/2022, revised August 2021, titled "Medication Administration and Oversight" stated, "Policy: ... A. ... The clinical record must contain physician orders for all medications prescribed for the patient ... B. Medications orders: 1) Orders must include the drug name (generic or trade name), dose, route, and frequency of administration ... 4) All PRN [as needed] medication orders must specify the purpose for the medication's use ... 11) The clinician will inform the physician of any concerns related to medications and will document any physician contact or orders ... C) Staff will teach the patient and/or caregiver and document the following in the clinical record: 1) Name and description of medication including any medication dosage change or newly prescribed medication ... F) .... If a verbal order is taken for a new medication or medication dosage changed, there needs to be a computer check of possible interactions. The Case Manager will notify the physician as applicable".An observation of a home visit was conducted on 4/7/2022, at 9:30 AM, for patient #1, start of care 5/11/2021, with home health aide (HHA) F. At 10:15 AM, the home folder was reviewed and failed to evidence a written schedule and information for the patient's medications. Review failed to evidence the required medication	G0616		

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G0616	Continued from page 17 schedule in the patient's home to include but not limited to the name, dosage, and route for the patient's current medications.	G0616		
G0716	<p>Preparing clinical notes</p> <p>CFR(s): 484.75(b)(6)</p> <p>Preparing clinical notes;</p> <p>This ELEMENT is NOT MET as evidenced by:</p> <p>Based on record review and interview, the home health agency failed to ensure all skilled professionals prepared clinical documentation with accurate information in 1 of 4 discharged records reviewed. (#6)The findings include:</p> <p>Review of an agency policy obtained 4/8/2022, revised 7/2021, titled, "Clinical Records – Documentation," stated, "...Policy: ... To present a true and accurate picture of the patient's status and the care provided. ... A clinical or visit note is to be used to document a contact with a patient that is written and dated by a clinician, and describes signs and symptoms, treatment and drugs administered, including any reactions of the patient, progress towards goals, and any changes in physical, emotional, or social conditions which may affect outcomes or response to care..."Clinical record review on 4/6/2022 for patient #6, start of care 2/17/2022, for certification period 2/17/2022 to 4/17/2022, evidenced an agency document titled, "PT [physical therapy] – Initial Evaluation," digitally signed by physical therapist K, dated 2/19/2022, which had a section titled, "Encounter Notes," which stated, "...patient and caregiver notified of anticipated discharge Planning date a week of [sic] 03-13-22 Pt. [patient] &amp; PCG [patient caregiver] is in agreement."Clinical record review on 4/6/2022 for patient #6 evidenced agency documents titled, "PT – Home Visit," digitally signed by physical therapist K, dated 2/21/2022, 2/23/2022, 2/26/2022, 3/1/2022, 3/3/2022, and 3/5/2022, which had a section titled, "Encounter Notes," which all stated, "...Patient and caregiver notified of anticipated discharge Planning date a week of [sic] 03-13-22 Pt. &amp; PCG is in agreement."Clinical record review on 4/6/2022 for patient #6 evidenced agency documents titled, "PT – Home Visit," digitally signed by physical therapist K, dated 3/8/2022, 3/10/2022, 3/11/2022, 3/17/2022, 3/21/2022, 3/22/2022, and 3/24/2022, which had a section</p>	G0716		

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G0716	Continued from page 18 titled, "Encounter Notes," which stated, "...Patient and caregiver notified of anticipated discharge Planning next week Pt. & PCG is in agreement [sic]." The physical therapist failed to accurately document the correct discharge plan in the clinical record. During an interview on 4/8/2022 at 12:07 PM, administrator A indicated the physical therapist's documentation was an error.  410 IAC 17-14-1(c)(5)-THERAPIST	G0716		
G1022	Discharge and transfer summaries  CFR(s): 484.110(a)(6)(i-iii)  (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or  (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or  (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer.  This ELEMENT is NOT MET as evidenced by:  Based on record review and interview, the home health agency failed to send complete discharge summaries in 4 of 4 discharge records reviewed. (#3, #4, #6, #7) The findings include:  1. Review of an agency policy obtained 4/8/2022, revised 8/2021, titled, "Discharge & Transfer" stated, "...Discharge/Transfer Summary: A completed discharge summary will be sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA within five business days of the patient discharge. A completed transfer summary will be sent to the health care facility within (2) two business days of a planned transfer, if the patient's care will immediately continue in a health care facility. A completed transfer summary	G1022		

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>157536</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>04/08/2022</b>
NAME OF PROVIDER OR SUPPLIER <b>METHODIST HOME CARE SERVICES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>303 E 89TH AVENUE, SUITE A, ROOM 117 , MERRILLVILLE, Indiana, 46410</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G1022	Continued from page 19 will be sent within (2) two business days to the health care facility and/or responsible health care provider upon becoming aware of an unplanned transfer."2. Clinical record review on 4/6/2022 for patient #7, start of care 2/26/2022, certification period 2/26/2022 – 4/26/2022, evidenced an agency document titled, "HH [home health] Transfer/Discharge Summary Status." This document failed to evidence documentation of laboratory data, patient medications, patient outcomes in meeting the goals on the plan of care, and the type and frequency of services provided.3. Clinical record review on 4/6/2022 for patient #6, start of care 2/17/2022, certification period 2/17/2022 – 4/17/2022, evidenced an agency document titled, "HH Transfer/Discharge Summary Status." This document failed to evidence documentation of laboratory data, patient medications, patient outcomes in meeting the goals on the plan of care, and the type and frequency of services provided. 4. Clinical record review on 4/8/2022, for patient #3, start of care 3/6/2022, primary diagnosis Lymphedema (a condition caused by a blockage in the immune and circulatory systems), evidenced an agency document titled "HH [home health] Transfer/Discharge Summary Status" which indicated the patient was discharged on 4/1/2022. Review of this document failed to evidence current medications at the time of discharge were listed on the discharge summary. Review failed to evidence types of disciplines and frequency of visits. Review failed to evidence patient outcomes for all disciplines.5. Clinical record review on 4/8/2022, for patient #4, start of care 3/18/2022, diagnoses included but not limited to hypertension (elevated blood pressure), and type 2 diabetes with hyperglycemia (elevated blood sugar levels), evidenced an agency document titled "HH [home health] Transfer/Discharge Summary Status" which indicated the patient was discharged on 4/1/2022. Review of this document failed to evidence current medications at the time of discharge were listed on the discharge summary. Review failed to evidence types of disciplines and frequency of visits. Review failed to evidence patient outcomes for all disciplines.6. During an interview on 4/8/2022, at 1:00 PM, administrator A indicated the missing items from the discharge summaries is an issue with the electronic medical record system. 410 IAC 17-15-1(a)(6)	G1022		