

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2353071	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2024
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CLINICAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8102 GEORGIA STREET , MERRILLVILLE, Indiana, 46410	
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N0000	Initial Comments This visit was for a State Re-Licensure survey of a Home Health Provider. Survey Dates: 2/22/2024 to 2/27/2024 12-Month Unduplicated Skilled Admissions: 356 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QR: A 1 3/03/24	N0000		
N0446	Home health agency administration/management CFR(s): 410 IAC 17-12-1(c)(3) Rule 12 410 IAC 17-12-1(c)(3) Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the Administrator failed to employ qualified personnel with completed criminal background checks in 3 of 8 personnel record reviews with direct patient contact. (RN 1, LPN 1, HHA 2) The findings include: The personnel records for Registered Nurse (RN) 1, first patient contact date 01/17/2020, Licensed Practical Nurse (LPN) 1, first patient contact date 4/16/2020, and Home Health Aide (HHA) 2, first patient contact date 02/02/2024, each failed to evidence a	N0446		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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N0446	Continued from page 1 background check. During an interview on 02/27/2024, at 2:47 PM, the Administrator indicated he was in charge of hiring personnel by reviewing new hire paperwork and had not reviewed the paperwork in "awhile." The Administrator indicated he was unaware criminal background checks had not been completed.	N0446		
N0456	Home health agency administration/management CFR(s): 410 IAC 17-12-1(e) Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the Administrator failed to ensure an ongoing quality assurance program was in place to ensure identified problems were resolved and improved patient care. The findings include: Review of the QAPI program provided indicated 17 agency patients were hospitalized in Quarter 1 of 2023, 20 patients were hospitalized in Quarter 2 of 2023, and 16 patients were hospitalized in Quarter 3 of 2023. The QAPI program failed to evidence data and improvement actions that were taken related to the hospitalizations. The program information provided failed to evidence any data since Quarter 3 of 2023, September 30, 2023. During an interview on 2/27/2024, at 2:44 PM, the Administrator indicated there was no data yet for Quarter 4 of 2023 and indicated he was unsure what the improvement plans were to address patient care. The Administrator indicated an improvement action plan was a good idea for the patient hospitalizations but was not aware of any the agency had in place.	N0456		
N0458	Home health agency administration/management CFR(s): 410 IAC 17-12-1(f)	N0458		

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N0458	<p>Continued from page 2</p> <p>Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:</p> <p>(1) Receipt of job description.</p> <p>(2) Qualifications.</p> <p>(3) A copy of limited criminal history pursuant to IC 16-27-2.</p> <p>(4) A copy of current license, certification, or registration.</p> <p>(5) Annual performance evaluations.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and interview, the agency failed to ensure personnel records included a copy of current licensure, annual evaluations, job descriptions, background checks, and orientation to the job in 8 of 9 personnel records reviewed. (Clinical Manager, Alternate Clinical Manager, RN 1, LPN 1, LPN 2, HHA 1, HHA 2, PTA 2)</p> <p>The findings include:</p> <p>1. A personnel record review for Registered Nurse (RN) 1, first patient contact date 1/17/2020, indicated the licensure expired 10/31/2023 and failed to evidence current licensure. Review failed to evidence a background check.</p> <p>2. A personnel record review for Licensed Practical Nurse (LPN) 1, first patient contact date 4/16/2020, failed to evidence a background check, job description, and job orientation.</p> <p>3. A personnel record review for Home Health Aide (HHA) 2, first patient contact date 2/2/2024, failed to evidence a background check.</p> <p>4. A personnel record review for the Clinical Manager, date of hire 6/9/2021, failed to evidence a performance evaluation since 9/14/2022.</p> <p>During an interview on 2/26/2024, at 2:25 PM, the</p>	N0458		

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N0458	<p>Continued from page 3 Clinical Manager indicated there was no additional performance evaluation in the record but there should be one done annually in March.</p> <p>5. A personnel record review for the Alternate Clinical Manager, date of hire 11/27/2023, failed to evidence a job orientation.</p> <p>During an interview on 2/26/2024, at 2:21 PM, Administrative Assistant 4 indicated there was no job orientation for the Alternate Clinical Manager.</p> <p>6. A personnel record review for HHA 1, first patient contact date 1/2/2024, failed to evidence a job description and job orientation.</p> <p>During an interview on 2/26/2024, the Clinical Manager indicated she remembered giving HHA 2 the job orientation and job description but could not recall if it was returned.</p> <p>7. A personnel record review for LPN 2, first patient contact date 4/3/2023, failed to evidence a current nurse license, a background check, and a job orientation.</p> <p>During an interview on 2/26/2024, at 2:47 PM, Administrative Assistant 4 indicated the file did not include a job orientation.</p> <p>8. A personnel record review for Physical Therapy Assistant (PTA) 2, first patient contact date 1/13/2024, failed to evidence a background check.</p> <p>9. During an interview on 2/26/2024, at 3:16 PM, Administrative Assistant 4 indicated the licenses were current but not added to the personnel files.</p> <p>10. During an interview on 2/26/2024, at 2:41 PM, the Clinical Manager indicated she was not aware criminal background checks were required.</p>	N0458		
N0464	<p>Home health agency administration/management</p> <p>CFR(s): 410 IAC 17-12-1(i)</p> <p>Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:</p> <p>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step</p>	N0464		

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N0464	<p>Continued from page 4 tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with:</p> <p>(A) a documented:</p> <p>(i) history of tuberculosis;</p> <p>(ii) previously positive test result for tuberculosis; or</p> <p>(iii) completion of treatment for tuberculosis; or</p> <p>(B) newly positive results to the tuberculin skin test; must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must:</p> <p>(A) be completed annually; and</p> <p>(B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on a tuberculosis evaluation may not:</p> <p>(A) work in the home health agency; or</p> <p>(B) provide direct patient contact; unless approved by a physician to work.</p> <p>(6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:</p> <p>(A) working for the home health agency; or</p> <p>(B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p>	N0464		

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N0464	Continued from page 5 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure staff providing direct patient care were evaluated for tuberculosis (TB, a contagious disease that usually affects the lungs) with a 2 step test upon hire if no documentation was provided of a negative test within the previous 12 months and an annually screening thereafter in 2 of 8 direct personnel records reviewed. (PTA 2, LPN 1) The findings include: 1. A personnel record review for Physical Therapy Assistant (PTA) 2, date of hire 1/8/2024 and first patient contact date 1/13/2024, failed to evidence a 2nd step TB skin test. During an interview on 2/26/2024, at 2:49 PM, the Clinical Manager indicated she asked PTA 2 about the 2nd step TB test and PTA 2 never got back to the agency about it. 2. A personnel record review for Licensed Practical Nurse (LPN) 1, date of hire 3/2/2020, 4/16/2020, which failed to evidence any TB skin tests or annual screening. During an interview on 2/26/2024, at 1:18 PM, Administrative Assistant 4 indicated there was no other documentation for LPN 1 for the personnel file.	N0464		
N0466	Home health agency administration/management CFR(s): 410 IAC 17-12-1(j) Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to maintain separate medical files and treated medical records as confidential in 2 of 9 personnel records	N0466		

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N0466	Continued from page 6 reviewed. (PT 1, HHA 1) The findings include: 1. A personnel record review for Physical Therapist (PT) 1 evidenced a COVID-19 vaccination record in the personnel file not maintained separately and confidential. 2. A personnel record review for Home Health Aide (HHA) 2 evidenced a health physical form in the personnel file not maintained separately and confidential. 3. During an interview on 2/26/2024, at 2:47 PM, Administrative Assistant 4 indicated the medical documents should have been filed separately in the medical file.	N0466		
N0470	Home health agency administration/management CFR(s): 410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the control of communicable disease in 3 of 4 home visits. (Patient #1, 2, 4) The findings include: 1. Review of an undated policy titled "Nursing/Home Health Aide Bag Policy" stated, "... Place bag on ... a bag barrier. This bag should never be placed on the floor ... wash hands before removing supplies from the bag...." 2. During an observation on 2/23/2024, at 2:35 PM, at the home of Patient #1, HHA 2 placed visit bag on the floor of the patient's bedroom without a barrier between the bag and the floor. HHA 2 was observed entering the main compartment of the visit bag to remove supplies and apply gloves to hands without first performing hand hygiene. At 2:58 PM, HHA 2 was observed removing the gloves and was not observed performing hand hygiene. At 3:01 PM, HH2 was observed applying gloves before completing documentation and cleaning supplies and was not observed performing hand hygiene after removing gloves and before applying clean gloves. During an interview on 2/26/2024, at 3:09 PM, the	N0470		

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N0470	<p>Continued from page 7</p> <p>Clinical Manager indicated staff should wash hands or apply hand sanitizer before entering the visit bag and indicated hands should be washed after glove removal before applying new gloves.</p> <p>3. During a home visit for Patient #2 on 2/23/2024 at 10:45 AM, PT (Physical Therapist) 1 dropped a small plastic bag containing equipment on the floor. PT 1 was observed picking up the bag from the floor and placing it on a barrier on a chair. When preparing to leave the visit, PT 1 placed the plastic bag inside of their supply bag without cleaning the outside of the plastic bag.</p> <p>During an interview on 2/23/2024 at 3:30 PM, the Clinical Supervisor indicated the inside of the clinician's supply bag is a clean area. When informed of the findings, the Clinical Supervisor indicated PT 1 should have disinfected the outside of plastic bag before returning it to the supply bag.</p> <p>4. During a home visit on 2/26/2024 at 3:25 PM, LPN (Licensed Professional Nurse) 1 was observed removing a dressing from a wound on the back of Patient #4's lower leg while they sat in a recliner. LPN 1 failed to place a barrier under the Patient's leg. After LPN removed the dressing, the Patient rested their leg, putting the open wound in contact with the unclean recliner surface.</p> <p>During an interview on 2/26/2024 at 4:10 PM, LPN 1 indicated she usually placed a roll cushion under the Patient's leg above the wound to prevent it from touching the recliner, but she forgot to today.</p>	N0470		
N0472	<p>Q A and performance improvement</p> <p>CFR(s): 410 IAC 17-12-2(a)</p> <p>Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and interview, the agency failed</p>	N0472		

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N0472	<p>Continued from page 8 to maintain a quality assessment and performance improvement (QAPI) program that used objective data and reflected the complexity of the services and failed to take actions that resulted in improvement of the agency's performance.</p> <p>The findings include:</p> <p>Review of the QAPI program provided for indicated there were 17 patients were hospitalized in Quarter 1 of 2023, 20 patients were hospitalized in Quarter 2 of 2023, and 16 patients were hospitalized in Quarter 3 of 2023. Review failed to evidence data and improvement actions related to the hospitalizations. The program documentation indicated of their patients, there were 12 infections which included 3 wound infections in Quarter 1 of 2023. The information revealed in Quarter 2 of 2023, there were 31 infections, 19 of these were wound infections and in Quarter 3 of 2023, there were 13 infections to include 9 wound infections. The action plan in Quarter 1 of 2023 was to continue to monitor infections and there was no additional performance action noted related to infections. There was no data or performance action plan related to wounds. Review failed to evidence any data since Quarter 3 of 2023, September 2023.</p> <p>During an interview on 02/27/2024, beginning at 12:14 AM, the Clinical Manager indicated there was no hospitalization log or data related to hospitalizations. The Clinical Manager indicated there was no data yet for Quarter 4 of 2023 and there was no data related to wounds. The Clinical Manager indicated QAPI was new to her and was still learning it.</p>	N0472		
N0504	<p>Patient Rights</p> <p>CFR(s): 410 IAC 17-12-3(b)(2)(D)(i)</p> <p>Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows:</p> <p>(2) The patient has the right to the following:</p> <p>(D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows:</p> <p>(i) The home health agency shall advise the patient in advance of the:</p> <p>(AA) disciplines that will furnish care; and</p> <p>(BB) frequency of visits proposed to be furnished.</p>	N0504		

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N0504	<p>Continued from page 9</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review and interview, the agency failed to provide the patient with a schedule of staff visits in 4 of 4 home visits conducted (Patients #1, 2, 3, 4).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A review of a policy titled "Patient Bill of Rights and Responsibilities", revised 3/2019, indicated patients have the right to be informed of their visit schedule and frequency. 2. An observation of a home visit for Patient #2 on 2/23/2024 at 10:45 AM failed to evidence a schedule of visits in the home. <p>During an interview on 2/23/2024 at 11:10 AM, PT 1 indicated the patient's book from the agency was probably at a family member's home, and they did not give out any other written schedule.</p> <ol style="list-style-type: none"> 3. An observation of a home visit for Patient #3 on 2/26/2024 at 9:30 AM failed to evidence a schedule of visits in the home. <p>During an interview on 2/23/2024 at 10:04 AM, Patient #3 indicated they probably had a book from the agency in the stack of papers on the floor, but it was not used.</p> <p>During an interview on 2/23/2024 at 10:04 AM, RN 1 indicated she did not write in the calendar in the book but tells the patient when she will be there next at each visit.</p> <ol style="list-style-type: none"> 4. An observation of a home visit for Patient #4 on 2/26/2024 at 3:25 PM failed to evidence a schedule of visits in the home. A review of the book from the agency failed to evidence a completed calendar of visits. <p>During an interview on 2/26/2024 at 4:04 PM, Patient #4 indicated the agency did not give them a written schedule of visits, and that the nurse told them when the next visit should be when they were there.</p> <p>During an interview on 2/26/2024 at 11:14 AM, the Clinical Supervisor indicated staff should be completing and updating the calendar in the patient books at their visits. When informed of the findings, the Clinical Supervisor indicated she was going to</p>	N0504		

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N0504	Continued from page 10 educate staff to use the patient books for schedules in the homes.	N0504		
N0522	<p>Patient Care</p> <p>CFR(s): 410 IAC 17-13-1(a)</p> <p>Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review and interview, the agency failed to follow the written plan of care in 3 of 4 patients with a home visit (Patient #1, 2, 3).</p> <p>The findings include:</p> <p>1. A review of an agency policy titled "Care Planning Process", revised 3/2018, indicated patient care should be appropriately provided by following a care plan created to meet each patient's specific needs and problems.</p> <p>2. During an observation of care at the home of Patient #1 on 2/23/2024, from 2:35 PM to 3:07 PM, with Home Health Aide (HHA) 2, the aide was not observed to comb the patient's hair. HHA 2 was observed asking the patient when the last bowel movement was, to which the patient indicated was earlier that morning. HHA 2 was not observed recording the bowel movement.</p> <p>A review of the HHA (Home Health Aide) Care Plan, certification period 1/17/2024 to 3/16/2024, evidenced the HHA should have performed the following tasks for Patient #1 at each visit: comb hair, assist with dressing, incontinence care, skin care, record last BM (bowel movement), assist with ambulation, and light housekeeping. A visit note dated 2/2/2024 failed to evidence the HHA combed the patient's hair, provided skin care, and recorded the last BM. A visit note dated 2/13/2024 failed to evidence the HHA combed the patient's hair, assisted with dressing, provided incontinence care, recorded the last BM, assisted with ambulation, and provided light housekeeping. A review of the aide visit note completed by HHA 2 dated 2/23/2024, failed to evidence the aide recorded the bowel movement as directed by the care plan.</p> <p>During an interview on 2/27/2024 at 1:21 PM, the Clinical Supervisor indicated the HHA should have performed tasks as directed in the HHA Care Plan, and</p>	N0522		

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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CLINICAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8102 GEORGIA STREET , MERRILLVILLE, Indiana, 46410	
(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
N0522	<p>Continued from page 11 if tasks were not performed because the patient refused, the HHA should document it and inform the nurse. The Clinical Supervisor indicated the clinical record failed to evidence the HHA performed duties as assigned at each visit or patient refusal of care.</p> <p>3. A review of the HHA Care Plan, certification period 1/24/2024 to 3/23/2024, evidenced the HHA should have measured Patient #2's heart rate and respirations at each visit. HHA visit notes dated 1/24/2024, 1/31/2024 and 2/14/2024 failed to evidence the HHA measured the patient's heart rate and respirations.</p> <p>During an interview on 2/27/2024 at 1:34 PM, the Clinical Supervisor indicated the clinical record failed to evidence the HHA measured the Patient's heart rate and respirations on 1/24/2024, 1/31/2024 and 2/14/2024.</p> <p>4. A review of the Plan of Care, certification period 12/30/2023 to 2/27/2024, indicated Patient #3 was to receive weekly skilled nursing visits for management of heart failure, requiring LVAD (a device that helps pump blood from the lower chambers of the heart to the rest of the body) placement. The Plan of Care indicated the nurse should perform a complete physical assessment each visit, assess for signs and symptoms of infection, and reconcile medications as indicated.</p> <p>During observation of a re-certification home visit on 2/26/2024 at 9:47 AM, RN (Registered Nurse) 1 lifted the Patient's shirt, exposing a dressing on the upper left side of their abdomen, covering the insertion of site of the tubing that connected to the LVAD machine. RN 1 did not remove the dressing or observe the site where the tubing entered the Patient's skin. Observation of the visit failed to evidence RN 1 reviewing the patient's medication list with the patient or looking at the medications in the home.</p> <p>A review of the Patient's electronic medical record failed to evidence a skilled nurse visit was made the week of 12/31/2023 to 1/6/2024 and the week of 1/7/2024 to 1/13/2024. A note indicated the nursing visit for 1/9/2024 (Tuesday) was missed because the patient had a doctor appointment.</p> <p>During an interview on 2/26/2024 at 10:00 AM, RN 1 indicated the Patient's family member changed the dressing three times a week and would change it later that day. When asked how she assessed the site for signs of an infection, RN 1 indicated the family member knew what to look for because they were taught, and she did not remove the dressing to visualize the site</p>	N0522		

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N0522	Continued from page 12 anymore, only when it was first inserted a few months ago. During an interview on 2/27/2024 at 10:25 AM, RN 1 indicated the visit observed was a recertification visit, and medications get reconciled at recertification. RN 1 indicated he/she performed a medication reconciliation by asking the patient if there were any changes to the medications they took. During an interview on 2/27/2024 at 3:00 PM, the Clinical Supervisor indicated the nurse should remove the dressing and visualize the insertion site of the LVAD tubing at least once a week to assess for infection, even if the family is doing the other dressing changes. The Clinical Supervisor indicated the nurse should have gone through the current list of medications the agency has one by one with the patient and / or compare it to medication bottles in the home in order to perform a medication reconciliation. The Clinical Supervisor indicated there should have been a nurse visit the week of 12/31/2023 to 1/6/2024, but there was not, and the nurse should have attempted to re-schedule the 1/9/2024 visit for later that week.	N0522		
N0524	Patient Care CFR(s): 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations.	N0524		

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N0524	<p>Continued from page 13</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and interview, the agency failed to ensure the plan of care included all necessary treatments and safety precautions in 1 of 1 clinical record reviewed with a LVAD {Patient #3} and 1 of 1 clinical record reviewed with a PEG tube (Patient #5).</p> <p>The findings include:</p> <p>1. A review of a policy titled "Plan of Care – CMS #485 and Physician Orders", revised 3/2019, indicated each patient must receive an individualized plan of care which included all care and services necessary to meet the needs of the patient.</p> <p>2. A review of the Plan of Care, certification period 12/30/2023 to 2/27/2024, indicated the nurse was to provide management of Patient #3's LVAD (a device that helps pump blood from the lower chambers of the heart to the rest of the body), but failed to evidence dressing / site care of the LVAD. The plan of care evidenced the Patient was taking Warfarin (a blood thinner) daily but failed to evidence Bleeding Precautions.</p> <p>During an interview on 2/26/2024 at 9:59 AM, RN 1 indicated the insertion site of the LVAD was a small incision that the Patient's family cleansed with alcohol and covered with gauze three times a week.</p> <p>During an interview on 2/27/2024 at 3:10 PM, the Clinical Supervisor indicated Bleeding Precautions should be included in the Plan of Care for Patient #3, but they were not. The Clinical Supervisor indicated the Plan of Care should have included what the site care was for the LVAD, including who was performing the care and when, but it did not.</p>	N0524		

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N0524	Continued from page 14 3. A review of the Plan of Care, certification period 1/20/2024 to 3/19/2024, evidenced Patient #5 was receiving feedings via a PEG tube (a tube inserted through the abdomen into the stomach). The plan of care failed to evidence PEG tube site care as well as how feedings were to be given and at what frequency. During an interview on 2/27/2024 at 2:02 PM, the Clinical Supervisor indicated the Plan of Care should include specific instruction on how the tube feeding was being given as well as what the site care should be for the PEG tube, but it did not.	N0524		
N0542	Scope of Services CFR(s): 410 IAC 17-14-1(a)(1)(C) Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, the nurse failed to revise the plan of care in 1 of 1 patient records with a home visits conducted with an RN (Registered Nurse) (Patient #3). The findings include A policy titled "Nursing Services", dated 3/2018, indicated the Registered Nurse should initiate the plan of care and revise it as necessary. A review of the plan of care, certification period 12/30/2023 to 2/27/2024 indicated the nurse should assess Patient #3's IV site for infection, educate the Patient & caregiver about the IV site, and flush the IV line with saline before and after each blood draw and as needed to maintain patency. An observation of a home visit on 2/26/2024 at 9:47 AM failed to evidence Patient #3 had an IV. During an interview on 2/27/2024 at 10:25 AM, RN 1 indicated the Patient used to have a PICC line (a long-term use IV), but it was removed a few months ago. During an interview on 2/27/2024 at 3:04 PM, the Clinical Supervisor indicated the nurse should have removed the orders / instructions related to the IV	N0542		

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N0542	Continued from page 15 when the patient's PICC line was removed.	N0542		
N0544	<p>Scope of Services</p> <p>CFR(s): 410 IAC 17-14-1(a)(1)(E)</p> <p>Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:</p> <p>(E) Prepare clinical notes.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review and interview, the RN (Registered Nurse) failed to document complete assessments in 1 of 1 clinical record reviewed with a LVAD (Patient #3) and in 1 of 1 clinical record reviewed with a PEG tube (Patient #5).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A review of a policy titled "Nursing Services", revised 3/2018, indicated RNs were responsible for preparing clinical notes. 2. During observation of a home visit on 2/26/2024 at 9:47 AM, RN 1 lifted Patient #3's shirt, exposing a dressing on the upper left side of their abdomen, covering the insertion of site of the tubing that connected to the LVAD (a device that helps pump blood from the lower chambers of the heart to the rest of the body) machine. <p>A clinical record review evidenced the Patient had the LVAD since the recertification visit on 12/26/2024. Nurse visit notes by RN 1 dated 1/16/2024, 1/23/2024, 2/12/2024 and 2/19/2024 failed to evidence an assessment of the LVAD / dressing.</p> <p>During an interview on 2/26/2024 at 9:59 AM, RN indicated she did not provide any care related to the LVAD, she only looked at the dressing covering the LVAD insertion site.</p> <p>During an interview on 2/27/2024 at 3:13 PM, the Clinical Supervisor indicated RN 1 should have documented an assessment of at least the LVAD dressing at every visit, but she did not.</p> <ol style="list-style-type: none"> 3. A clinical record review evidenced Patient #5 had a PEG tube (a tube inserted through the abdomen into the stomach) inserted during a hospitalization from 	N0544		

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N0544	Continued from page 16 1/31/2021 to 2/8/2024. A review of the Resumption of Care note dated 2/9/2024 as well as skilled nurse visit notes dated 2/12/2024, 2/14/2024 and 2/16/2024 by RN 1 failed to evidence an assessment of the PEG tube site. During an interview on 2/27/2024 at 2:08 PM, the Clinical Supervisor indicated each nurse visit note failed to include an assessment of the PEG tube.	N0544		
N0554	Scope of Services CFR(s): 410 IAC 17-14-1(a)(2)(B) Rule 14 Sec. 1(a) (2) (B) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (B) Prepare clinical notes. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the LPN (Licensed Practical Nurse) failed to complete accurate visit notes in 2 of 2 active records with an LPN providing wound care (Patient #1, 4). The findings include: 1. A review of a policy titled "Nursing Services", revised 3/2018, indicated LPNs were responsible for preparing clinical notes. 2. A review of the plan of care, certification period 1/17/2024 to 3/16/2024, evidenced Patient #1 was to receive one skilled nursing visit per week. A review of the electronic medical record evidenced an empty skilled nursing visit note on 2/14/2024 and failed to evidence another skilled nurse visit that week. During an interview on 2/27/2024 at 1:21 PM, the Clinical Supervisor indicated the LPN made the visit, but the record failed to evidence a completed note for that visit. The Clinical Supervisor indicated the nurse should have completed the note within 3 days of the visit. 3. A review of the plan of care for Patient #4, for the certification period 01/17/2024 to 3/16/2024, evidenced the following orders for care to a wound on the back of Patient's lower leg: cleanse with wound wash, apply Silvadene (a cream used to prevent and treat wound infections) to wound bed, apply skin barrier to surrounding skin, cover with dry gauze and wrap with rolled gauze.	N0554		

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N0554	Continued from page 17 In the narrative portion of skilled nurse visit notes dated 01/31/2024, 02/19/2024 and 02/23/2024 LPN 1 indicated she cleansed the wound, applied Xeroform (a specialized non-adherent gauze dressing) to the wound bed, applied skin barrier to surrounding skin, covered with dry gauze, and wrapped with rolled gauze. In a visit note dated 2/5/2024, LPN 1 indicated she taught the patient about both Silvadene and Xeroform, but failed to indicate what wound care was performed. During an interview on 02/26/2024 at 3:47 PM, LPN 1 indicated Xeroform was not used on the patient's wound since they started using Silvadene about a month ago. On 02/27/2023 at 1:43 PM, when informed of the findings, the Clinical Supervisor indicated LPN 1's notes should reflect what wound care was performed at that visit, but she probably copied and pasted outdated information from an earlier note.	N0554		
N0608	Clinical Records CFR(s): 410 IAC 17-15-1(a)(1-6) Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure clinical notes were written for services provided and maintained in the patient's clinical	N0608		

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N0608	Continued from page 18 record in 1 of 2 active records receiving HHA (Home Health Aide) services (Patient #1). The findings include: 1. A review of a policy titled "Medical Record Content", revised 3/2018, indicated each medical record should include dates care and services are provided, staff and title of who provided the care. 2. A review of a policy titled "Home Health Aide Documentation", revised 3/2018, indicated the HHA (Home Health Aide) should document services rendered and this documentation should be filed in the medical record within 7 days of the visit. 3. A review of the plan of care, certification period 1/17/2024 to 3/16/2024, evidenced Patient #1 was to receive two home health aide visits the week of 2/4/2024 to 2/9/2024. A review of the electronic medical record evidenced an empty visit note for 1 of the 2 HHA visits (on 2/6/2024) scheduled that week. During an interview on 2/27/2024 at 1:21 PM, the Clinical Supervisor indicated the HHA completed the visit, but the record failed to evidence a completed note for that visit. The Clinical Supervisor indicated the HHA should have completed the note within 3 days of the visit.	N0608		
N0610	Clinical Records CFR(s): 410 IAC 17-15-1(a)(7) Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure clinical record entries were correct in 1 of 1 home visits with a home health aide. (Patient #1) The findings include: During an observation on 2/23/2024, from 2:35 PM to 3:07 PM, at the home of Patient #1, Home Health Aide (HHA) 2 did not provide range of motion exercises. Patient #1 was not in the bed and HHA 2 did was not observed to have provided assistance with turning and repositioning. At 2:49 PM, HHA 2 was observed assisting	N0610		

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N0610	Continued from page 19 Patient in the shower. A clinical record review for Patient #1 evidenced a home health aide visit note completed by HHA 2 and dated 2/23/2024, which failed to indicate assistance with the shower. The documentation indicated HHA 2 provided range of motion exercises and assistance with turning and repositioning. During an interview on 2/27/2024, at 1:27 PM, the Clinical Manager indicated the aide should have marked the assistance with the shower as provided and indicated the aide should not document turning and repositioning was provided, indicated Patient was not bedbound. The Clinical Manager indicated tasks that were not performed should not have been documented.	N0610		
N9999	Final Observations IC 16-27-1.5-5 Approved dementia training for home health aides https://iga.in.gov/laws/2023/ic/titles/16#16-27-1.5-5 Sec. 5. (a) This section applies to a registered home health aide who: (1) is employed as a home health aide; and (2) provides care to an individual who has been diagnosed with or experiences symptoms of Alzheimer's disease, dementia, or a related cognitive disorder (b) As used in this section, "approved dementia training" refers to a dementia training program: (1) for use in training home health aides in the care of individuals described in subsection (a)(2); and (2) that has been approved by the state department under subsection (f). (c) Not later than sixty (60) days after the date on which a home health aide is initially hired to care for an individual with Alzheimer's disease, dementia, or a related cognitive disorder, the home health aide shall complete at least six (6) hours of approved dementia training. (d) Before December 31 of each year, a home health aide who has been employed as a home health aide for at least one (1) year shall complete at least three (3)	N9999		

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N9999	<p>Continued from page 20 hours of approved dementia training.</p> <p>(e) A home health aide who:</p> <p>(1) has received the training required by subsections (c) and (d);</p> <p>(2) has been employed as a home health aide for at least twenty-four (24) consecutive months; and</p> <p>(3) is hired by a home health agency;</p> <p>is not required to repeat the training required by this section.</p> <p>(f) The state department shall do the following:</p> <p>(1) Identify and approve each dementia training program that meets the following requirements:</p> <p>(A) The dementia training program includes education concerning the following:</p> <p>(i) The nature of Alzheimer's disease, dementia, and other related cognitive disorders.</p> <p>(ii) Current best practices for caring for and treating individuals with dementia.</p> <p>(iii) Guidelines for the assessment and care of an individual with dementia.</p> <p>(iv) Procedures for providing patient centered quality care.</p> <p>(v) The daily activities of individuals with dementia.</p> <p>(vi) Dementia related behaviors, communication, and positive intervention.</p> <p>(vii) The role of an individual's family in caring for an individual with dementia.</p> <p>(B) The dementia training program:</p> <p>(i) must be culturally competent; and</p> <p>(ii) may be provided online.</p> <p>(2) Establish and implement a process for state department approval of a dementia training program.</p> <p>(g) To the extent allowed by 42 CFR 484.80, the hours of approved dementia training completed under this</p>	N9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2353071	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2024
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CLINICAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8102 GEORGIA STREET , MERRILLVILLE, Indiana, 46410	
(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
N9999	<p>Continued from page 21 section satisfies an equivalent number of hours of the home health aide training required by 42 CFR 484.80.</p> <p>(h) An entity that provides approved dementia training shall provide to each home health aide who successfully completes the training a certificate of completion.</p> <p>(i) A home health aide:</p> <p>(1) is responsible for maintaining the home health aide's certificate of completion; and</p> <p>(2) may use the certificate of completion as proof of compliance with this section.</p> <p>Based on record review and interview, the agency failed to use an approved dementia training program to ensure home health aides received 6 hours of dementia training within the first 60 days of employment for care of patients with a diagnosis of dementia or related cognitive disorder in 2 of 2 active home health aides (HHA) employed by the agency (HHA 1, HHA 2).</p> <p>The findings include:</p> <p>1. A clinical record review for Patient #2 indicated the diagnoses included, but were not limited to, Alzheimer's disease, and indicated Home Health Aide (HHA) 1 provided care.</p> <p>A personnel record review for Home Health Aide (HHA) 1, date of hire 12/5/2023, failed to evidence dementia training.</p> <p>2. A personnel record review for HHA 2, date of hire 1/24/2024, failed to evidence dementia training.</p> <p>3. During an interview on 2/26/2024, at 2:39 PM, the Clinical Manager indicated she was not aware of the requirement for dementia training and did not have a process for aides to complete dementia training. The Clinical Manager indicated all aides were hired to care for patients with dementia or other related cognitive disorders.</p>	N9999		