

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 000	<p>INITIAL COMMENTS</p> <p>This visit was a Federal Recertification, State Re-licensure, Complaint, Emergency Preparedness, and Focused Infection Control survey. The survey visit took place 1/12/2021 - 1/20/2021, and was fully extended.</p> <p>Complaint:</p> <p>IN00328185 - unsubstantiated with unrelated findings</p> <p>Facility ID: IN009912 Provider ID: 157511</p> <p>This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.</p>	G 000			
G 444	<p>Quality Review Completed 02/16/2021 Area 1 State toll free HH telephone hotline CFR(s): 484.50(c)(9)</p> <p>Be advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local HHAs.</p> <p>This ELEMENT is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure patients were advised of the state toll free home health telephone hotline, its contact information, and that its purpose is to receive complaints or questions about local home health agencies in 1 of 3 home visits conducted. (#1)</p>	G 444			

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

TITLE

(X6) DATE

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 444	Continued From page 1  The findings include:  1. Record review on 1/19/2021, evidenced an agency policy titled "Reporting, Investigating and Documentation", dated 1/14/2018, which stated, "... During the initial home visit the patient, family or guardian will be informed orally and in writing of the telephone number of the Home health Hotline established by the state, hours of operation, and purpose of the hotline...."  2. Record review evidenced an agency policy titled "Patient Bill of Rights and Responsibilities", dated 1/14/2018, which stated, "... Patients have the right: ... i. Be advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local Home Health Agencies...."  3. Observation of a home visit for patient #1 on 1/13/2021 at 9:20 a.m., failed to evidence written information in the patient's home about the state home health hotline.  During an interview on 1/13/2021 at 9:25 a.m., person D, caregiver to patient #1, indicated she was unaware of the state home health hotline.  During an interview on 1/15/2021 at 4:18 p.m., the administrator indicated the agency failed to ensure patients had information about the state home health hotline.	G 444			
G 528	17-12-3(b)(2)(C) Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1)	G 528			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 528	<p>Continued From page 2</p> <p>The patient's current health, psychosocial, functional, and cognitive status; This ELEMENT is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the comprehensive assessment was individualized and reflected the patient's current status in 7 of 9 clinical records reviewed. (#2, #3, #4, #6, #7, #8, #9)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Record review on 1/19/2020, evidenced an agency policy titled "Comprehensive Assessment of Patients", dated 1/14/2018. This policy stated, " ... The comprehensive assessment conducted by the nurse or the rehabilitation skilled professional includes at a minimum the following information: a. The patient's current health, psychological, functional, and cognitive status...."</li> <li>Record review evidenced an agency policy titled "Registered Nurse" dated 1/14/2018, which stated, "Skilled nursing services are provided by and under the supervision or [sic] a registered nurse ... b. performs the initial physical examination and complete [sic] all patients assessments. c. Establish goals and discharge plans with the patient and/or caregiver d. Documents the patient's medications on the Medication Profile sheet..."</li> <li>Clinical record review for patient #2, start of care 09/24/2020, evidenced an agency document dated 11/4/2020, signed by the administrator, titled "OASIS [Outcome and Assessment Information Set] [a standardized assessment used in home health] Follow-Up". This document was identified by the administrator as the</li> </ol>	G 528			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 528	<p>Continued From page 3</p> <p>comprehensive assessment. This document had a subcategory titled, "(M1021) Primary Diagnosis &amp; (M1023) Other Diagnoses" which stated, " ... Other Diagnoses ... colostomy [an opening that connects the colon to the surface of the abdomen] ... urinary incontinence [lack of control over urination]...." This assessment did not indicate the patient had a catheter [a tube used to drain the bladder].</p> <p>Clinical record review evidenced an agency document titled "Skilled Nursing Note", dated 12/16/2020, signed by employee I. In this assessment, the categories "Gastrointestinal" [involving the stomach and intestine], "Genitourinary" [involving the genital and urinary organs], and "Catheter" [a tube used to drain urine the bladder] were assessed as "WNL" [within normal limits]. This assessment failed to indicate the patient had a colostomy and was incontinent.</p> <p>During an interview on 1/20/2021 at 11:00 a.m., the administrator indicated the patient did not have a catheter and the documentation of the patient's assessment was not accurate.</p> <p>4. Clinical record review on 1/19/2021 for patient #6, with start of care 6/17/2019, and certification period 10/9/2020 to 12/7/2020, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". This plan of care had a subcategory titled, "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)" which stated, " ... Services Coordinated with [entity A]. Attends dialysis Tuesday, Thursday and Saturday...."</p> <p>Clinical record review evidenced a document</p>	G 528			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 528	<p>Continued From page 4</p> <p>received on 1/20/2021 at 9:44 a.m., from person B, the administrator of entity A. This document was titled "Dialysis Order Report" and dated 1/14/2021. This report stated, "Access Tunneled Catheter Right IJ [intra-jugular] Vein [a tube placed into the vein in the neck, used for hemodialysis] Placement Date 10/23/2019".</p> <p>Clinical record review evidenced an agency document titled "Comprehensive Assessment", dated 11/9/2020, signed by the administrator. This comprehensive assessment failed to evidence the patient had a dialysis catheter.</p> <p>During an interview on 1/20/2021 at 9:50 a.m., person C, caregiver to patient #6, indicated the patient had a dialysis catheter.</p> <p>During an interview on 1/20/2021 at 11:55 a.m., the administrator indicated the agency failed to ensure the comprehensive assessment was complete and reflected the patient's current status.</p> <p>5. Clinical record review on 1/19/2021 for patient #7, with start of care 4/1/2020 and certification period 9/28/2020 to 11/26/2020, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". This plan of care evidenced a subcategory titled, "Other Pertinent Diagnoses" which stated, " ... Blindness, both eyes...."</p> <p>Clinical record review evidenced an agency document titled, "Recertification / Follow-Up", dated 9/19/2020, and signed by the administrator. This document was identified by the administrator as the comprehensive assessment. This assessment failed to indicate the patient was</p>	G 528			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 528	<p>Continued From page 5</p> <p>blind and failed to evidence a musculoskeletal assessment.</p> <p>When informed of the findings on 1/20/2021 at 2:30 p.m., the administrator was silent and offered no additional documentation.</p> <p>6. Clinical record review on 1/19/2021 for patient #3, evidenced an agency document titled "Adult Re-Assessment" dated 9/18/2020 and signed by employee C, RN. This document had subsections titled "SENSORY STATUS and CARE COORDINATION" which failed to evidence any documentation.</p> <p>During an interview on 1/21/2021 at 10:45 a.m., the clinical manager indicated those areas must have been missed when documenting.</p> <p>7. Clinical record review on 1/19/2021 for patient #4, evidenced an agency document titled "Comprehensive Adult Assessment," signed by employee C and dated 5/15/2020. This document had subsections titled "IMMUNIZATION/SCREENING TESTS, and PATIENT HISTORY AND DIAGNOSIS," which failed to evidence any documentation.</p> <p>During an interview on 1/20/2021 at 3:19 p.m., the administrator confirmed the documents did not have the employee's credentials. She indicated she did not know why the notes were not signed by staff she would look into this. She indicated she was unsure why parts of the assessment were not filled out.</p>	G 528			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 528	<p>Continued From page 6</p> <p>8. Clinical record review on 1/19/2021 for patient #8, start of care 8/21/2020, evidenced an untitled document dated 10/15/2020 with a subsection titled "ALLERGIES," which stated, "ASPIRIN RELATED MEDICATION PENICILLIN ...."</p> <p>Clinical record review on 1/19/2021 for patient #8, start of care 8/21/2020, evidenced a document titled "Comprehensive Adult Assessment" dated 8/21/2020, and signed by the clinical manager. This document had a subsection titled "Patient History and diagnosis which stated "Allergies' Seafood Chocolate ...." This document failed to evidence patient #8's aspirin and Penicillin allergies.</p> <p>During an interview on 1/20/2021 at 1:45 p.m., the clinical manager indicated she was unaware of patient #8's allergies to aspirin and Penicillin. She indicated the patient did not tell her she was allergic to those medications.</p> <p>9. Clinical record review on 1/19/2021 for patient #9, start of care 6/3/2020, evidenced an untitled document that stated, "REASON FOR REFERRAL Primary Diagnosis left leg ulcer Secondary Diagnosis: Non venous insufficiency PAD [peripheral artery disease]...."</p> <p>Clinical record review on 1/19/2021 for patient #9, start of care 6/3/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 10/1/2020 to 11/29/2020, signed by the clinical manager. This document had a section subtitled "Primary Diagnosis" which stated "Essential (primary) Hypertension [high blood pressure] Other Pertinent Diagnoses: Type</p>	G 528			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 528	<p>Continued From page 7</p> <p>2 Diabetes mellitus [high blood sugar] Atrial Heart Disease Hyperlipidemia [high cholesterol] Gastro-esophageal reflux disease [GERD]" This document failed to evidence patient #9 had a leg ulcer, non-venous insufficiency and PAD.</p> <p>Clinical record review on 1/19/2021, evidenced an agency document titled "Comprehensive Assessment" dated 8/8/2020, which had a subsection titled "Primary Diagnosis and Other diagnosis," which failed to evidence patient #9 had a leg ulcer, non-venous insufficiency and PAD.</p> <p>During clinical record review on 1/20/2021 at 3:00 p.m., the clinical manager was informed of the concern with the patient's complete diagnoses. The clinical manager remained silent.</p> <p>Clinical record review on 1/19/2021 for patient #9, evidenced an agency document titled "Comprehensive Adult Assessment-Resumption of Care," signed by employee I, LPN and dated 8/18/2020. This document had subsections titled "SENSORY STATUS, WOUND CARE/INTERVENTIONS, and FALL RISK ASSESSMENT," which failed to evidence any documentation.</p> <p>Clinical record review on 1/19/2021 for patient #9, evidenced an agency document titled "Recertification/Follow-Up," signed by the clinical manager and dated 9/30/2020. This document had subsections titled "Musculoskeletal" and "Wound Location," which failed to evidence any documentation. There was a subsection titled "Wound Care," which stated "N/A [not applicable]" which failed to evidence the wound care being provided to patient #9.</p>	G 528			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 528	Continued From page 8	G 528			
G 530	<p>17-14-1(a)(1)(A) Strengths, goals, and care preferences CFR(s): 484.55(c)(2)</p> <p>The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; This ELEMENT is not met as evidenced by: Based on record review and interview, the home health agency failed to identify patient centered goals, strengths and care preferences in 2 of 3 discharged clinical records reviewed, out of a total of 9 clinical records reviewed. (#5, #9)</p> <p>The findings include:</p> <p>1. Record review evidenced an agency policy titled "Registered Nurse" dated 1/14/2018, which stated, "Skilled nursing services are provided by and under the supervision or [sic] a registered nurse ... b. performs the initial physical examination and complete [sic] all patients assessments. c. Establish goals and discharge plans with the patient and/or caregiver...."</p> <p>2. Clinical record review on 1/19/2020 for patient #9, evidenced an agency document titled "Comprehensive Adult Assessment-Resumption of Care" signed by employee I, LPN [licensed practical nurse] and dated 8/18/2020. This document had a subsection titled "MEASURABLE GOALS AND OUTCOMES" which failed to evidence any documentation.</p>	G 530			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 530	Continued From page 9 During an interview on 1/20/2021 at 11:40 a.m., the clinical manger indicated the section should be completed on the assessment.  3. Clinical record review on 1/19/2021 for patient #5, start of care 4/11/2017, evidenced an unsigned agency document titled "Adult Re-Assessment," dated 1/23/2020. This document had subsections titled "MEASURABLE OUTCOMES AND GOALS" which failed to evidence any documentation  During an interview on 1/20/2021 at 11:23 a.m., the clinical manger indicated as far as the VA [Veterans Administration] was concerned the assessment was complete.	G 530			
G 534	Patient's needs CFR(s): 484.55(c)(4)  The patient's medical, nursing, rehabilitative, social, and discharge planning needs; This ELEMENT is not met as evidenced by: Based on clinical record review and interview, the home health agency failed to meet the patient's needs as evidenced in the comprehensive assessment, in 1of 4 discharged clinical records reviewed, out of a total of 9 clinical records reviewed. (#4).  The findings include:  Record review evidenced an agency policy titled "Registered Nurse" dated 1/14/2018, which stated, "Skilled nursing services are provided by and under the supervision or [sic] a registered nurse ... b. performs the initial physical examination and complete all patient	G 534			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 534	<p>Continued From page 10</p> <p>assessments. c. Establish goals and discharge plans with the patient and/or caregiver d. Documents the patient's medications on the Medication Profile sheet ... a. the Home Health aide is provided with a written care plan that outlines tasks to be performed c. The home health aide is required to notify the nurse of any changes to the patient's condition ... 3. Regularly reviews the patient's nursing needs, 7. Coordinates services b. Reviews the medical record for completeness. 8. Consults with the physician and ensures that physician orders for change in services and/or treatment are submitted to the physician for signature ...."</p> <p>Record review evidenced an undated agency policy titled "Plan of Treatment" which stated, "Purpose: To establish and maintain a Plan of Treatment that is coordinated with the patient's primary physician. Policy: a. Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately in the patient's place of residence. Care services provided will follow a written plan of treatment established and periodically reviewed by the patient's primary physician. b. Home health agency personnel shall promptly notify a patient's physician or other appropriate medical personnel and guardian, if any, or [sic] any significant physical or mental changes observed or reported by the patient. In the care of medical emergency, the home health agency will know in advance which emergency systems contact.</p> <p>Record review evidenced an agency policy titled "Plan of Treatment-485" dated 1/14/2018 which stated, "Policy 1. Patients are accepted for treatment based on the reasonable expectation</p>	G 534			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 534	<p>Continued From page 11</p> <p>that the patient's medical, nursing, rehabilitative and social needs in his/her residence ... 2. The individualized plan of care specifies the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment ...."</p> <p>Clinical record review on 1/19/2021 for patient #4, start of care 10/4/2017, evidenced a document titled "Approved Referral for Medical Care," dated 2/21/2020, which had a subsection titled "Service Requested," which stated, "Homemaker-Home Health Aide ... Up to 9 hours per week Homemaker/Home Health Aide services to assist with activities of daily living ... Does the patient require assistance with personal care? Yes Bathing Yes Dressing Yes Toileting Yes Transferring Yes ...."</p> <p>Clinical record review evidenced an agency document titled "Adult Re-Assessment" dated 07/16/2020 and signed by employee C. This document had a subsection titled "ADLs/IADLs" which indicated patient #4 was dependent for toileting hygiene, required substantial/maximum assistance with oral hygiene. Patient #4 was dependent for rolling right to left in bed, sitting to lying, lying to sitting on the side of the bed, sit to stand, chair/bed to chair transfers, and toileting transfers. There was a subsection titled "Functional Level" which indicated patient #4 was completely dependent for grooming, dressing upper and lower body and "unable to participate in bathing effectively and is totally bathed by another person ... Orders for treatment ... HHA [Home Health Aide] Visit Frequency 2 x W [twice per week]." The comprehensive assessment and subsequent documents evidenced patient #4 needed a home health aide</p>	G 534			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 534	<p>Continued From page 12</p> <p>to assist with activities of daily living. The home health agency failed to provide a home health aide to meet the needs of patient #4 in accordance with the comprehensive assessment.</p> <p>Clinical record review on 1/19/2021, evidenced an agency document titled "Skilled Nursing Note", which was dated 4/14/2020 and signed by employee C, RN [registered nurse]. This nursing note had a subsection titled "TEACHING/INSTRUCTIONS," which stated Instructed son to turn pt [patient] Q 2 [every two (2) hours] to prevent skin breakdown ...."</p> <p>Clinical record review on 1/19/2021 for patient #4, evidenced an agency document titled "Narrative Note", dated 1/21/2020, signed by employee C, which stated, [Patient #4 is a complete in ADLs [activities of daily living] except for eating. He is incontinent of bowel and bladder ...."</p> <p>Clinical record review on 1/19/2021 for patient #4, start of care 10/4/2017, evidenced an agency document titled "Skilled Nursing Note", which was dated 3/24/2020, and signed by employee C, RN. This nursing note had a subsection titled "DATA incontinent brief noted with incontinence of urine. Person J states he changes pt Q2-3 hours" and a subsection titled "TEACHING/INSTRUCTIONS, which stated, "instructed patient caregiver (son) to turn patient Q 2 to prevent decubus [sores from pressure] ...."</p> <p>Clinical record review evidenced an agency document titled "Narrative Note", dated 1/21/2020, signed by employee C, which stated, [Patient #4 is a complete in ADLs except for eating. He is incontinent of bowel and bladder ...."</p>	G 534			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 534	Continued From page 13  Clinical record review evidenced agency documents titled "Skilled Nursing Note", which were dated 4/14/2020 and 6/2/2020 and signed by employee C, RN. These nursing notes had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed caretaker (son) to turn pt Q 2 to prevent pressure ulcers ...."  Clinical record review evidenced an agency document titled "Skilled Nursing Note", which was dated 4/9/2020, and signed by employee C, RN. This skilled nursing note had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed son to turn pt Q 2 to prevent pressure on coccyx [sic] [tailbone] area ...."  Clinical record review evidenced an agency document titled "Skilled Nursing Note", which was dated 4/2/2020 and signed by employee C, RN. This skilled nursing note had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed caregiver (son) to turn pt Q 2 to relieve pressure from buttocks and prevent pressure sores ...."  Clinical record review evidenced an agency document titled "Skilled Nursing Note", which was dated 3/31/2020 and signed by employee C, RN. This skilled nursing note had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed caregiver (son) to turn pt Q 2 to prevent bed sores ...."  Clinical record review evidenced an agency document titled "Case Conference", which was dated 3/30/2020 and signed by employee A, clinical manager and employee C, RN. This document indicated patient #4 was bedbound and	G 534			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 534	<p>Continued From page 14 incontinent of bowel and bladder.</p> <p>Clinical record review evidenced an agency document titled "Narrative Note", dated 7/16/2020, signed by employee C, which stated, "Patient #4 is a complete in ADLs ...."</p> <p>Clinical record review evidenced agency documents titled "Skilled Nursing Note", which were dated 5/28/2020 and 6/23/2020 and signed by employee C, RN. These skilled nursing notes had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed son to turn pt Q 2 to prevent skin breakdown ...."</p> <p>Clinical record review evidenced an agency document titled "Comprehensive Adult Assessment", which was dated 4/14/2020 and signed by employee C, RN. This document had a subsection titled "ADLs/IADLs" which indicated patient #4 was dependent with bathing, upper and lower body dressing, rolling right and left, sitting to lying, and chair/bed transfers, there was another subsection titled "elimination status," which indicated he was incontinent of bowel and bladder.</p> <p>Clinical record review evidenced agency documents titled "Skilled Nursing Note", which were dated 4/16/2020, 5/26/2020, 6/9/2020 and 6/11/2020, signed by employee C, RN. These skilled nursing notes had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed son to turn pt Q 2 to prevent skin breakdown ...."</p> <p>Clinical record review evidenced an agency document titled "Skilled Nursing Note", which was</p>	G 534			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 534	<p>Continued From page 15</p> <p>dated 4/30/2020 and signed by employee C, RN. This skilled nursing note had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed son/caregiver to turn pt Q 2 to prevent skin breakdown ...."</p> <p>Clinical record review evidenced an agency document titled "Adult Reassessment" which was dated 5/20/2020 and signed by employee C, RN. This document had a subsection titled "ADLs/IADLs" which indicated patient #4 was dependent with bathing, upper and lower body dressing, rolling right and left, and siting to lying. There was a subsection titled "elimination status," which indicated he was incontinent of bowel and bladder. The subsection titled "Medications," indicated patient #4 was dependent on another person in order to take his medications.</p> <p>Clinical record review evidenced an agency document titled "Skilled Nursing Note", which was dated 6/30/2020 and signed by employee C, RN. This skilled nursing note had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed caregiver to turn client Q 2 to prevent skin breakdown ...."</p> <p>Clinical record review evidenced an agency document titled "Skilled Nursing Note", which was dated 5/20/20 and signed by employee C, RN. This skilled nursing note had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed son to turn pt Q 2 to prevent bed sores ...."</p> <p>Clinical record review evidenced an agency document titled "Skilled Nursing Note", which was dated 5/5/2020 and signed by employee C, RN. This skilled nursing note had a subsection titled</p>	G 534			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 534	<p>Continued From page 16</p> <p>"TEACHING/INSTRUCTIONS," which stated, "Instructed son (caregiver) to turn pt Q 2 to prevent pressure wounds ...."</p> <p>Clinical record review evidenced an agency document titled "Skilled Nursing Note", which was dated 5/7/2020 and signed by employee C, RN. This skilled nursing note had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed caregiver to turn pt Q 2 to prevent bed sores ...."</p> <p>Clinical record review evidenced an agency document titled "Skilled Nursing Note", which was dated 5/19/2020 and signed by employee C, RN. This skilled nursing note had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed son to turn pt Q 2 to prevent wounds ...."</p> <p>Clinical record review evidenced an agency document titled "Skilled Nursing Note", which was dated 5/21/2020 signed by employee C, RN. This skilled nursing note had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed pt's son to turn pt Q 2 to prevent skin bedsores and relieve pressure off buttocks ...."</p> <p>Clinical record review evidenced an agency document titled "Skilled Nursing Note", which was dated 7/14/2020 and signed by employee C, RN. This skilled nursing note had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed son (caregiver) to check incontinent brief q 2-3 hours and change...."</p> <p>Clinical record review evidenced an agency document titled "Skilled Nursing Note", which was dated 7/16/2020 and signed by employee C, RN.</p>	G 534			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 534	<p>Continued From page 17</p> <p>This skilled nursing note had a subsection titled "TEACHING/INSTRUCTIONS," which stated, "Instructed caregiver to turn pt Q 2 to prevent bedsores ...."</p> <p>Clinical record review evidenced an agency document titled "Addendum to Initial History and Physical", which was dated 5/20/2020 and signed by employee C, RN. This addendum stated, "[Pt #4] requires 24 hour supervision ...."</p> <p>During an interview on 1/20/2021 at 3:18 p.m., the clinical manager indicated the patient could have benefited from a home health aide but the VA [Veteran Association] does not pay for one. She indicated patient #4 received bathing services from the personal care attendant, and the son took care of his daily needs and was his primary caretaker. She indicated the patient's son would leave while the attendant was there to do whatever he needed to get done, like grocery shopping.</p> <p>On 1/26/2021 at 1:20 p.m., person G returned a call that was placed on 1/19/2021 at 1:19 p.m., during this phone interview person G indicated they were never offered any additional assistance for care for patient #4 and person did the best he could, but it was very difficult on the family as person #4 needed 24-hour care and had become bedbound and unable to do anything for him/herself. Person G indicated they asked if there was anything additional the agency could do and the family was told no, but they could get hospice services. Person #4 stated "We were not ready for that, we just wanted some additional help because [patient #4] required twenty four hour care."</p>	G 534			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 534	Continued From page 18 17-14-1(a)(1)(B)	G 534			
G 536	A review of all current medications CFR(s): 484.55(c)(5)  A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the correct medications were listed on the plan of care in 2 of 9 clinical records reviewed. (#1, #9)  The findings include:  1. Record review on 1/19/2021, evidenced an undated agency policy titled "Clinical records," which stated " ... 1. The clinical record includes: ... All interventions including medication administration, treatments and services, and responses to those interventions ...."  2. Record review on 1/19/2021, evidenced an agency document titled "Medication Drug Review," and dated 1/14/2018, which stated "Policy: 1. The nurse reviews all medications patients are currently using in order to identify any potential adverse effects and drug reactions, including ineffective therapy and non-compliance with drug therapy ...."  3. Record review on 1/19/2021, evidenced an undated agency document titled "Medications," which stated, "Purpose:: To provide guides to ensure that all medications are listed and	G 536			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 536	<p>Continued From page 19</p> <p>reviewed for contraindications ... f. Medications are reviewed to identify possible and effective drug therapy or adverse reactions, drug allergies, significant side effects in contraindicated medications at least every sixty (60) days, on admission to the agency, during resumption of care re certification and at discharge ... e. The nurse will review all medications in the home, their actions, side effects, proper dosage, and use under the guidance of the patient's physician ...."</p> <p>4. Record review evidenced an undated agency policy titled "Case Conference / Consultation Clinical Chart Review". This policy stated, "... During the chart review the medication profile and 485 [the patient's plan of care] during the case conference is updated...."</p> <p>5. Clinical record review on 1/19/2021 for patient #9, start of care 6/3/2020, evidenced a dated document titled "[Hospital K] Discharge Summary 8/7/2020 which stated, "Summary of Current Medications ... Glipizide 10 mg take one tablet by mouth twice a day before meals for diabetes ...."</p> <p>Clinical Record review on 1/19/2021 for patient #9 evidenced an untitled medical record dated 11/25/2020, which had a subsection titled "Active Outpatient Medications," which stated " ... Glipizide 10 mg take one tablet by mouth twice a day before meals for diabetes...."</p> <p>Clinical Record review on 1/19/2021 for patient #9 evidenced a document titled "Approved Referral for Medical Care," dated 11/27/2020. This document had a list of patient #9's current medications which stated " ... Glipizide 10 mg</p>	G 536			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 536	<p>Continued From page 20</p> <p>take one tablet by mouth twice a day before meals for diabetes...."</p> <p>Clinical record review on 1/19/2021 for patient #9 evidenced a hospital document titled, "Active Outpatient Medications," dated 11/27/2020, which stated, "Acetaminophen 500 mg [milligram] take one tab every six hours as needed for pain Albuterol/Ipratropium 20 mcg [microgram] one puff four times a day as needed for breathing ... Glipizide 10 mg take one tablet by mouth twice a day before meals for diabetes...."</p> <p>Clinical record review on 1/19/2021 for patient #9, start of care 6/3/2020, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 10/1/2020 to 11/29/2020, signed by Employee A, clinical manager and dated 9/30/2020. This document had a subsection titled "MEDICATIONS; Dose/Frequency/Route," which stated Acetaminophen 500 mg [milligram] Q [every] 6 hours PO [by mouth] PRN [as needed] Albuterol/Ipratropium 20 mcg [microgram] one puff QID [four (4) times a day] ... Glyburide 5 mg 2 tabs BID [twice per day] PO before meals ...." This document failed to include the correct medication (Glipizide) to control the patient #9's blood sugar, failed to evidence the indication for acetaminophen as needed and the indication for the as needed Albuterol/Ipratropium.</p> <p>Clinical record review on 1/19/2021 for patient #9 evidenced an agency document titled Medication Profile (Addendum to Comprehensive Assessment)" which was signed by Employee A, clinical manager and employee C, RN and was evidenced as reviewed on 6/3/2020, 7/30/2020,</p>	G 536			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 536	<p>Continued From page 21 8/7/2020, and 9/30/2020. This document stated, "Acetaminophen 500 mg po Q 6 hrs PRN pain ... Glyburide 5 mg 2 tabs BID glucose. This document failed to evidence the correct medication (Glipizide) prescribed to patient #9 for blood sugar management.</p> <p>During an interview on 1/20/2021 at 3:45 p.m., the administrator indicated they would add the indications for the medications. She indicated the medication was written in the nursing notes the way the patient takes the medication. When queried as to why medication for the patient's blood sugar was not the same as the medication on the records sent to the agency, the clinical manager indicated the nurse may have read the paperwork wrong. She stated, "It's an error."</p> <p>6. Clinical record review on 1/12/2020 for patient #1, with start of care 9/14/2020, and certification period 11/2/2020 to 12/31/2020, evidenced two agency documents titled "MEDICATION PROFILE" and "MEDICATION PROFILE ADDENDUM". The addendum evidenced the medication profile was reviewed on 12/30/2020 by the nurse. The medication profile stated, " ... Sertaline [an antidepressant] 25 mg [milligrams] p.o. [by mouth] daily ... ASA EC [enteric coated aspirin] 81 mg BID [twice a day] p.o. ...." The medication profile failed to evidence any vitamins, supplements, or pain medications.</p> <p>During an interview on 1/13/2021 at 9:25 a.m., person D, caregiver to patient #1, indicated</p>	G 536			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 536	Continued From page 22 patient #1 took aspirin 81 mg every other day, on even days, and did not take Sertaline. Person D indicated patient #1 also took Zinc and Vitamin C daily.  Clinical record review on 1/19/2021 evidenced a group of documents titled "Home Health Aide Documentation Sheet". The home health aide notes on the following dates all indicated the patient was given a pain pill by the patient's family member: 11/2/2020, 11/3/2020, 11/4/2020, 11/5/2020, 11/6/2020, 11/9/2020, 11/10/2020, 11/11/2020, 11/12/2020, 11/13/2020, 11/14/2020, 11/16/2020, 11/17/2020, 11/18/2020, 11/19/2020, 11/20/2020, 11/23/2020, 11/24/2020, 11/25/2020, 11/27/2020, 11/28/2020, 12/1/2020, 12/2/2020, 12/3/2020, 12/4/2020, 12/7/2020, 12/8/2020, 12/9/2020, 12/10/2020, 12/11/2020, 12/12/2020, 12/14/2020, 12/15/2020, 12/18/2020, 1/8/2021 and 1/9/2021.  During an interview on 1/20/2021 at 10:30 a.m., the administrator indicated the agency failed to ensure the patient's medication list was current and complete.	G 536			
G 572	17-14-1(a)(1)(B) 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 refers a patient under a	G 572			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 572	<p>Continued From page 23</p> <p>plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the plan of care was developed and individualized, included patient-specific discharge plans and patients received services in the plan of care in 7 of 9 clinical records reviewed. (#2, #3, #4, #5 #6, #7, #8)</p> <p>1. Record review on 1/19/2021, of an agency policy titled "Missed Visit Notes," dated 10/2018, stated "I. Purpose: Demonstrate compliance with Physician Orders. II. Policy Home visits are scheduled on a consistent basic [sic] according to the patient's availability. On admission the agency patients are provided with frequency and days home visit will be provided. III. Procedures: 1. Missed scheduled home visit are documented on a narrative note, stating the reason for the missed visit. Attempts will be made to re-schedule the missed visits within the same week if the patient is available. If the patient is unable to re-schedule a missed home visit to prevent non-compliance with the frequency order, the physician will be notified."</p> <p>2. Clinical record review on 1/19/2021 for patient #3, start of care 6/3/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE, for certification period 11/26/2020 to 1/24/2020 [sic] and signed by employee C, RN. This document had a subsection titled "Orders for Discipline and Treatments," which stated "SN [Skilled Nurse] 1-2 x week 9 Assess VS [vital signs and all body</p>	G 572			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 572	<p>Continued From page 24</p> <p>systems, med [medication] knowledge and complication, knowledge r/t [related to] dx[diagnosis]/care regimen and safety of client/environment and report s/s [signs/symptoms] necessitating medical attention to physician, Implement and instruct Universal precautions and Infection Control. Implement and instruct medication regimen, including dosage, side effects, name route, frequency, desired action and adverse side reactions. Assess medication compliance/ med set-up. Notify physician of B/P [blood pressure] &gt;160/90 &lt; 90/60, pulse rate &gt; 100 and &lt; 60. Instruct patient on diabetic care to include diet, activity, stress, foot care, skin care, s/s of complication of diabetes, s/s of hyper/hypo glycemia. Notify physician of blood sugar over 300 F [fasting] and under 60 F [fasting] set up medications weekly in mediplanner...."</p> <p>3. Clinical record review on 1/29/2021 for patient #3, evidenced an agency document titled "Skilled Nursing Note," signed by employee C, RN and dated 9/29/2020. This document had a subsection titled "Teaching/ Instruction" which failed to evidence the skilled nurse provided education to the patient. This document failed to evidence the skilled nurse followed physician orders as directed in the plan of care.</p> <p>During an interview on 1/20/2021 at 11:44 a.m., the clinical manager indicated patient #3 had a knowledge deficit so it was not expected they would learn the teaching, but they touch on a little bit every visit. She indicated they were mostly focusing on diabetes management.</p> <p>Clinical record review on 1/19/2021 for patient #3, start of care 6/3/2020, evidenced an agency</p>	G 572			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 572	<p>Continued From page 25</p> <p>document titled "Narrative Note" signed by employee C, RN and dated for 10/16/2020 which stated, "Missed visit. Pt attending funeral." The home health agency failed to ensure the skilled nurse followed the plan of care visit frequency.</p> <p>During an interview on 1/20/2021 at 10:40 a.m., the clinical manager indicated the physician was not notified of the missed visit.</p> <p>4. Clinical record review for patient #4, start of care 10/4/2017, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/22/2020 to 5/20/2020, which had a subsection titled "Order for Discipline and Treatment" which stated, "VA [Veteran Administration] fee based 1-2 x week 9 [1-2 times a week for 9 weeks]..."</p> <p>Clinical record review on 1/19/2021 for patient #4, evidenced an agency document titled "Narrative Note" signed by employee C, RN and dated 3/3/2020. This document stated "... attempted to reschedule visit for 3/3/2020 opted for regular visit on 3/5/2020..." The home health agency failed to ensure the skilled nurse followed the plan of care visit frequency.</p> <p>Clinical record review on 1/19/2021 for patient #4, start of care 10/4/2017, failed to evidence patient #3 was seen by skilled nursing the week of 5/11/2020. The home health agency failed to ensure the skilled nurse followed the plan of care visit frequency.</p> <p>During an interview on 1/20/2021 at 3:20 p.m., the clinical manager indicated the narrative note would state if the physician was called for the missed visit.</p>	G 572			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 572	<p>Continued From page 26</p> <p>5. Clinical record review on 1/19/2021 for patient #5, start of care 4/11/2017, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/27/2019 to 1/25/2020, which had a subsection titled "Order for Discipline and Treatment" which stated SN [skilled nurse] 1-2 x week 9 [1-2 times a week for 9 weeks]...."</p> <p>Clinical record review on 1/20/21 for patient #5, start of care 10/4/2017, failed to evidence patient #3 was seen by skilled nursing as ordered on the plan of care the week of 12/23/2020 and failed to evidence the physician was notified.</p> <p>During an interview on 1/20/2021 at 11:20 a.m., the clinical manager indicated she did not know if the physician was notified, it should be documented.</p> <p>6. Clinical record review on 1/19/2021 for patient #8, start of care 8/21/2020, evidenced an agency document titled "Narrative Note," which stated "PT [physical therapy] missed visit 11/24/20 Patient canceled PT due to medical surgical procedure. PT rescheduled for 11/27/2020 PT missed visit 11/27/20 Pt [patient] canceled PT due to medical surgical/ procedure. PT rescheduled for 12/1/2020." he home health agency failed to ensure the physical therapist followed the plan of care visit frequency.</p> <p>During an interview on 1/20/2021 at 1:47 p.m., the clinical manager indicated if the physician was notified of a missed visit the information would be in the narrative note.</p> <p>7. Clinical record review on 1/19/2021 for patient</p>	G 572			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 572	<p>Continued From page 27</p> <p>#2, start of care 09/24/2020, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician. This plan of care contained a subcategory titled "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)", which stated, "SN [skilled nurse] 2-3 x week 9 [2 to 3 times per week for 9 weeks] Vitals [vital signs-temperature, pulse, respiratory rate, and blood pressure] Q [each] visit measure wounds at least 1 time [sic] week ... Notify physician of ... change in wound status increased drainage, odor...."</p> <p>Clinical record review evidenced a group of documents titled "Skilled Nursing Note". The following notes, signed by employee I, failed to evidence the size, stage, shape, and measurement of the wound: 11/18/2020, 11/20/2020, 11/25/2020, 11/27/2020, 12/2/2020, 12/4/2020, 12/9/2020, 12/11/2020, 12/16/2020, 12/18/2020 and 1/15/2020. A nurse's note dated 11/30/2020, signed by the administrator, failed to indicate the stage of the wound. The skilled nurse failed to follow the physician signed plan of care.</p> <p>During an interview on 1/20/2021 at 10:47 a.m., when queried, the administrator indicated the patient's wound could not be measured.</p> <p>Clinical record review evidenced the nurse's notes dated 11/30/2020, 12/23/2020, and 12/28/2020, signed by the administrator, each evidenced wound measurements.</p> <p>During an interview on 1/20/2021 at 10:48 a.m., the administrator was presented these concerns and remained silent.</p>	G 572			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 572	<p>Continued From page 28</p> <p>8. Clinical record review on 1/19/2021 for patient #6, with start of care 6/17/2019, and certification period 10/9/2020 to 12/7/2020 evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". This document had a subcategory titled "Safety Measures:" which stated "Standard Precaution / Infection Control Fall Precautions".</p> <p>Clinical record review evidenced a group of agency documents titled "Skilled Nursing Note", dated 10/12/2020, 10/26/2020, 11/2/2020, 11/9/2020, 11/16/2020, 11/23/2020, and 11/30/2020. Each of these notes failed to evidence fall precautions. The skilled nurse failed to follow the medical plan of care.</p> <p>During an interview on 1/20/2021 at 11:50 a.m., the administrator indicated the agency failed to ensure fall precautions were maintained as ordered in the plan of care.</p> <p>Clinical record review evidenced a document titled "Medical Record / Consultation Sheet" from entity L, written by the patient's primary care physician, dated 11/19/2020. This document stated, " ... Chief Complaint: esrd [end stage renal disease] Patient History / Clinical Findings / Diagnosis (Co-Morbidities) : ESRD, HTN [hypertension], Blindness...." This medical record did not indicate the patient was diabetic.</p> <p>Clinical record review of the plan of care evidenced a subcategory titled "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)" which stated, " ... Instruct patient on diabetic care to include diet, activity, stress, foot care, skin care, S/S [signs and symptoms] of complication of diabetes, S/S of</p>	G 572			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 572	<p>Continued From page 29</p> <p>hypo / hyperglycemia [low or high blood sugar]...." The plan of care failed to be individualized to the patient.</p> <p>During an interview on 1/20/2021 at 9:48 a.m., person C, caregiver to patient #6, stated the patient, "hasn't been diabetic in over a year".</p> <p>During an interview on 1/20/2021 at 11:48, the administrator indicated the patient was blind, and unable to perform foot care or skin care.</p> <p>During an interview on 1/20/2021 at 11:50 a.m., the administrator indicated the agency failed to ensure the plan of care was individualized to the patient.</p> <p>9. Clinical record review on 1/19/2021 for patient #7, with start of care 4/1/2020, and certification period 9/28/2020 to 11/26/2020, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". This document had a subcategory titled "Safety Measures:" which stated "Use of assistive devices Keep pathways clear Fall Precautions...."</p> <p>Clinical record review evidenced a group of agency documents titled "Skilled Nursing Note", dated 9/28/2020, 9/30/2020, 10/3/2020, 10/7/2020, 10/10/2020, 10/12/2020, 10/14/2020, 10/16/2020, 10/19/2020, 10/21/2020, 10/24/2020, 10/26/2020, 10/28/2020, 10/31/2020, 11/2/2020, 11/4/2020, 11/6/2020, 11/9/2020, 11/11/2020, 11/13/2020, 11/16/2020, 11/18/2020, 11/21/2020, 11/23/2020 and 11/25/2020. Each of these skilled nursing notes failed to evidence keeping pathways clear and fall precautions as indicated on the plan of care.</p>	G 572			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 572	<p>Continued From page 30</p> <p>During an interview on 1/20/2021 at 11:50 2:20 p.m., the administrator indicated the agency failed to ensure keeping pathways clean and fall precautions were maintained as ordered in the plan of care.</p> <p>Clinical record review of the patient's plan of care evidenced a subcategory titled, "Other Pertinent Diagnoses" which stated, "Unspecified dementia without behavioral dis [disturbance] [a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems] ... Blindness, both eyes...."</p> <p>Review of the plan of care evidenced a subcategory titled, "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)", which stated, "SN [skilled nurse] 2-3 x week 9 [2 to 3 times per week for 9 weeks]. Assess VS [vital signs-temperature, pulse, respiratory rate, and blood pressure] and all body systems...."</p> <p>Clinical record review evidenced a group of agency documents titled "Skilled Nursing Note". The assessments dated 9/28/2020, 9/30/2020, 10/3/2020, 10/7/2020, 10/10/2020, 10/12/2020, 10/14/2020, 10/16/2020, and 11/18/2020 failed to evidence the patient was blind. The assessments with the following dates failed to evidence a musculoskeletal [relating to muscles and bones], neurological [relating to the brain and nerves], and skin assessment: 9/28/2020, 9/30/2020, 10/3/2020, 10/7/2020, 10/10/2020, 10/12/2020, 10/14/2020, 10/16/2020, 10/19/2020, 10/21/2020, 10/24/2020, 10/26/2020, 10/28/2020, 10/31/2020, 11/2/2020, 11/4/2020, 11/6/2020, 11/9/2020, 11/11/2020, 11/13/2020, 11/16/2020, 11/18/2020,</p>	G 572			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 572	<p>Continued From page 31 11/21/2020, 11/23/2020, and 11/25/2020.</p> <p>Clinical record review of the patient's plan of care evidenced a subcategory titled, "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)" which stated, " ... Instruct patient on diabetic care to include diet, activity, stress, foot care, skin care, S/S [signs and symptoms] of complication of diabetes, S/S of hypo / hyperglycemia [low or high blood sugar] ... Glucometer [machine that checks blood sugar] testing to be performed 2 times a day by caregiver...."</p> <p>Clinical record review of a skilled nursing note dated 11/16/2020, signed by employee I, LPN [licensed practical nurse], stated " ... Instruct client to monitor exp [expiration] date on insulin...."</p> <p>Clinical record review of a skilled nursing note dated 10/24/2020, signed by employee I, LPN, stated, " ... Instruct client to monitor BS [blood sugar] daily...." Review of a skilled nursing note dated 11/25/2020, signed by employee I, LPN, stated, " ... monitor BS [blood sugar] reading daily...."</p> <p>During an interview on 1/20/2021 at 2:30 p.m., the administrator indicated due to dementia, the patient was not able to learn about diabetic care. The administrator also indicated the patient was blind, unable to perform foot care or skin care, and unable to read an insulin vial.</p> <p>During an interview on 1/20/2021 at 2:30 p.m., the administrator indicated the skilled nurse failed to ensure the patient's blood sugar was monitored as ordered in the plan of care.</p>	G 572			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 572	Continued From page 32	G 572			
G 574	<p>During an interview on 1/20/2021 at 2:35 p.m., the administrator indicated the agency failed to ensure the plan of care was individualized to the patient.</p> <p>17-13-1(a) Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi)</p> <p>The individualized plan of care must include the following:</p> <ul style="list-style-type: none"> <li>(i) All pertinent diagnoses;</li> <li>(ii) The patient's mental, psychosocial, and cognitive status;</li> <li>(iii) The types of services, supplies, and equipment required;</li> <li>(iv) The frequency and duration of visits to be made;</li> <li>(v) Prognosis;</li> <li>(vi) Rehabilitation potential;</li> <li>(vii) Functional limitations;</li> <li>(viii) Activities permitted;</li> <li>(ix) Nutritional requirements;</li> <li>(x) All medications and treatments;</li> <li>(xi) Safety measures to protect against injury;</li> <li>(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.</li> <li>(xiii) Patient and caregiver education and training to facilitate timely discharge;</li> <li>(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;</li> <li>(xv) Information related to any advanced directives; and</li> <li>(xvi) Any additional items the HHA or physician</li> </ul>	G 574			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 574	<p>Continued From page 33 may choose to include. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the individualized plan of care included all medications and treatments in 6 of 9 clinical records reviewed. (#2, #3, #6, #7,#8, #9)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Record review on 1/19/2021, evidenced an agency policy titled "Plan of Treatment - 485", dated 1/14/2018. This policy stated, "Each patient receives an individualized written plan of care, including and [sic] revisions or additions ... The individualized plan of care specifies the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment including identification of the responsible disciplines and measurable outcomes anticipated will occur as a result of implementing and coordinating the plan of care ... The plan of care ... is 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 ... The plan of care includes the following: ... c. The types of services, supplies and equipment required ... i. services coordinated with other medical agencies ... n. All medications and treatments...."</li> <li>Record review on 1/19/2021, evidenced an undated agency policy titled "Plan of Treatment". This policy stated, "1. Purpose: To establish and maintain a Plan of Treatment that is coordinated with the patient's primary physician. 2. Policy: a. ... Care services provided will follow a written plan of treatment established and periodically</li> </ol>	G 574			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 574	<p>Continued From page 34</p> <p>reviewed by the patient's primary physician. b. Home Health agency personnel shall promptly notify a patient's physician or other appropriate medical personnel and guardian, if any, or [sic] any significant physical or mental changed [sic] observed or reported by the patient...."</p> <p>3. Clinical record review on 1/19/2021 for patient #2, with start of care 9/24/2021, and certification period 11/17/2020 to 1/15/2021, evidenced two documents from entity E. These documents were identified by the administrator as wound clinic notes, dated 11/23/2020 and 12/21/2020.</p> <p>Clinical record review evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician. This plan of care failed to evidence the patient received treatment at a wound clinic.</p> <p>During an interview on 1/20/2021 at 10:47 a.m., the administrator indicated the agency failed to ensure the plan of care included all treatments being received by the patient.</p> <p>Clinical record review of the plan of care evidenced a subcategory titled "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)", which stated, "SN [skilled nurse] 2-3 x week 9 [2 to 3 times a week for 9 weeks]. Vitals [vital signs-temperature, pulse, respiratory rate, blood pressure] Q [each] visit measure wounds at least 1 time week. Cleanse left buttock wound with normal saline or saline wound cleanser, pat dry, apply calcium alginate AG [a wound dressing that contains silver], ABD pad [a dry dressing], secure with tape 3 x week Monday, Wednesday and Friday...."</p>	G 574			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 574	<p>Continued From page 35</p> <p>Clinical record review of a wound clinic note from entity E dated 12/21/2020 stated, "Primary Wound Dressing ... Left Gluteus [buttock] Collagen with silver...."</p> <p>During an interview on 1/15/2021 at 4:30 p.m., the administrator indicated the agency failed to ensure the plan of care included the correct current wound care treatment.</p> <p>4. Clinical record review on 1/19/2021 for patient #6, with start of care 6/17/2019, and certification period 10/9/2020 to 12/7/2020, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". This plan of care had a subcategory titled "Medications: Dose / Frequency / Route (N)ew (C)hanged" which contained the order, "Dorzolamide 22.3 / Timolol 6.8 mg/ml OPTH soln [an eye drop used to reduce pressure in the eye] instill one gtt [drop] into". This order failed to evidence where the drop was to be placed and the how often it should be given.</p> <p>During an interview on 1/20/2021 at 11:55 a.m., the administrator indicated the agency failed to ensure the plan of care contained complete orders for each patient medication.</p> <p>5. Clinical record review on 1/19/2021 for patient #7, with start of care 4/1/2020, and certification period 9/28/2020 to 11/26/2020, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". This plan of care had a subcategory titled "Medications: Dose / Frequency / Route (N)ew (C)hanged" which contained the order, "Collagenase [an enzyme that breaks down</p>	G 574			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 574	<p>Continued From page 36</p> <p>collagen in damaged skin tissues and helps the body generate new, healthy tissue] 250 unt [units]/gm [gram] top [topical] oint [ointment] apply thickness of a nickel topically daily". This order failed to evidence the location of where the medication was to be used. This subcategory of Medications also included the order, "Quetiapine Fumarate [an anti-psychotic medication] 25 mg [milligram] 1/2 tab [tablet] Q [each] evening PO [by mouth] can take a second dose of 1/2 tablets on bad nights".</p> <p>Clinical record review of the plan of care evidenced a subcategory titled "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)", which stated, " ... Wound care as follows: Cleanse bilateral [left and right] heels with saline, apply iodisorb [an anti-microbial wound gel], wrap with kerlix [gauze roll] and secure with tape 2-3 x week [2 to 3 times per week]."</p> <p>During an interview on 1/20/2021 at 2:10 p.m., the administrator indicated Collagenase is not part of the current wound care and is not currently ordered for the patient.</p> <p>During an interview on 1/20/2021 at 2:40 p.m., the administrator indicated "bad nights" is not a clear indicator as to why a second dose of the medication should be given, and it was not a clear medication order.</p> <p>Clinical record review evidenced a document from entity L, titled "Home Wound Care Instructions", dated 10/22/2020 and signed by the physician, which stated, " ... Instructions: 1) Apply Iodosorb [an anti-microbial wound gel] to 3rd toe blister (abrasion R [right] foot) 2)</p>	G 574			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 574	<p>Continued From page 37</p> <p>Continue L [left] heel wound care with Prisma [a wound dressing with collagen] and / or Keracel Ag [a gelling fiber dressing]; cleanse with saline cover with sterile dressing."</p> <p>During an interview on 1/20/2021 at 1:57 p.m., the administrator indicated the wound care orders in the plan of care were incorrect and stated, "That was my doing. I wrote it wrong".</p> <p>6. Clinical record review on 1/19/2021 for patient #9, start of care 6/3/2020, evidenced a dated document titled "[Hospital K] Discharge Summary 8/7/2020 which stated, "Summary of Current Medications ... Glipizide 10 mg take one tablet by mouth twice a day before meals for diabetes ...."</p> <p>Clinical Record review on 1/19/2021 for patient #9 evidenced an untitled medical record dated 11/25/2020, which had a subsection titled "Active Outpatient Medications," which stated " ... Glipizide 10 mg take one tablet by mouth twice a day before meals for diabetes...."</p> <p>Clinical Record review on 1/19/2021 for patient #9 evidenced a document titled "Approved Referral for Medical Care," dated 11/27/2020. This document had a list of patient #9's current</p>	G 574			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 574	<p>Continued From page 38</p> <p>medications which stated " ... Glipizide 10 mg take one tablet by mouth twice a day before meals for diabetes...."</p> <p>Clinical record review on 1/19/2021 for patient #9 evidenced a hospital document titled, "Active Outpatient Medications," dated 11/27/2020, which stated, "Acetaminophen 500 mg [milligram] take one tab every six hours as needed for pain Albuterol/Ipratropium 20 mcg [microgram] one puff four times a day as needed for breathing ... Glipizide 10 mg take one tablet by mouth twice a day before meals for diabetes...."</p> <p>Clinical record review on 1/19/2020 for patient #9, start of care 6/3/2020, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 10/1/2020 to 11/29/2020, signed by Employee A, clinical manager and dated 9/30/2020. This document had a subsection titled "MEDICATIONS; Dose/Frequency/Route," which stated, "Acetaminophen 500 mg [milligram] Q [every] 6 hours PO [by mouth] PRN [as needed] Albuterol/Ipratropium 20 mcg [microgram] one puff QID [four (4) times a day] ... Glyburide 5 mg 2 tabs BID [twice per day] PO before meals ...." This document failed to include the correct medication (Glipizide) to control the patient #9's blood sugar and failed to evidence the indication for acetaminophen and the indication for the Albuterol/Ipratropium.</p> <p>Clinical record review on 1/19/2020 for patient #9, start of care 6/3/2020, evidenced an agency document titled Medication Profile (Addendum to Comprehensive Assessment)" which was signed by Employee A, clinical manager and employee</p>	G 574			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 574	<p>Continued From page 39</p> <p>C, RN and reviewed on 6/3/2020, 7/30/2020, 8/7/2020, and 9/30/2020. This document stated, "Acetaminophen 500 mg po Q 6 hrs PRN pain ... Glyburide 5 mg 2 tabs BID glucose. This document failed to evidence the correct medication (Glipizide) prescribed to patient #9 for blood sugar management.</p> <p>During an interview on 1/20/2020 at 3:45 p.m., the administrator indicated they would add the indications for the medications. She indicated the medication was written in the nursing notes the way the patient takes the medication. When queried on the medication for patient #9's high blood sugar not being the same as the medication on the medications lists, the clinical manager indicated the documentation may have been read wrong and responded, "It's probably an error."</p> <p>7. Clinical record review on 1/19/2020 for patient #8, start of care 8/21/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 10/20/2020 to 12/18/2020, signed by the clinical manager. This document had a subsection titled "MEDICATIONS: Dose/Frequency/Route," which stated. "Albuterol 90 mcg [micrograms oral inhal [inhale 2 puffs QID [four times a day PRN [as needed] ... Hydrophilic (Eucerin) cream [dry skin] top [topical] cream apply a small amount TID [three times a day] Lidocain [sic] 5% oint [ointment] [for pain]apply moderate amount topically TID ... Nystatin 100000/units/gm [gram] cream [antifungal] apply liberal amount topically Q [every] day ... Lidocaine 5% oint apply moderate amount TID ...." This documents failed to evidence the indication for the albuterol and there</p>	G 574			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 574	<p>Continued From page 40</p> <p>failed to be a location for the application of creams and ointments, in addition the document had duplicate Lidocaine orders.</p> <p>During an interview on 1/20/2021 at 1:43 PM., the clinical manager indicated there should be an indication for the albuterol and it would be added on to the plan of care. The clinical manager also indicated she was unsure why there were two lidocaine orders. In addition, she indicated they do not apply the creams and ointments that was why there was no application location on those orders.</p> <p>Clinical record review on 1/19/2021 for patient #8, evidenced an untitled document dated 10/15/2020 with subsections titled "ALLERGIES," which stated, "ASPIRIN RELATED MEDICATION PENICILLIN ... "Chief Complaint" which stated "Polyarthritis" ... Patient History / Clinical Findings / Diagnosis (Co-Morbidities)" which stated "Pt [patient with polyarthritis LBP [lower back pain] COPD [chronic obstructive pulmonary disease]/ASTHMA, depression, impaired cognition, osteoporosis [weak brittle bones] Lumbar spondylitis [degeneration of the lower spine] ...."</p> <p>Clinical record review on 1/19/2021 for patient #8, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 10/20/2020 to 12/18/2020 and signed by the clinical manager. This document had subsections titled "Primary Diagnosis" which stated "Polyarthritis." "Other Diagnoses" which stated, "Hypertension [high blood pressure] chronic obstructive pulmonary disease, major depressive disorder and allergy" and a subsection titled "Allergies" which stated,</p>	G 574			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 574	<p>Continued From page 41</p> <p>"Seafood chocolate." This document failed to evidence the patient's allergy to penicillin and aspirin related medication. This document also failed to evidence the patient diagnoses of impaired cognition, osteoporosis, Lumbar spondylitis, asthma, and lower back pain.</p> <p>During an interview on 1/20/2021 at 1:45 p.m., the clinical manager indicated they put the diagnoses and allergies on the plan of care that were given to them from the patient.</p> <p>8. Clinical record review on 1/20/2021 for patient #3, start of care 12/2/2019, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 9/27/2020 to 11/25/2020, signed by EMPLOYEE C, RN. This document had a subsection titled "MEDICATIONS: Dose/Frequency/Route," which stated benzonatate for cough 100 mg TID PO PRN. This document failed to evidence the indication for benzonatate.</p> <p>Clinical record review on 1/19/2021 for patient #3, start of care 12/2/2019, evidenced a document titled "VA [veterans administration] Medical documentation." This document had a subsection titled "Home care orders- Skilled Nursing Orders" which stated, " ... Diet: Diabetic" .... This document failed to include the correct diet for patient #3.</p> <p>Clinical record review on 1/19/2021 for patient #3, start of care 12/2/2019, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 9/27/2020 to 11/25/2020,</p>	G 574			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 574	Continued From page 42 signed by employee C, RN. This document had a subsection titled "Nutrition Req [requirement] which stated, "Regular Low NA [sodium] ...." This document failed to include the correct diet for patient #3.  Clinical record review on 1/19/2021 for patient #3, start of care 12/2/2019, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 9/27/2020 to 11/25/2020, signed by employee C, RN. This document had a subsection titled "Nutrition Req [requirement] which stated, "Regular" ...." This document failed to include the correct diet for patient #3.  During an interview on 1/20/21 at 10:41 a.m., the clinical manager indicated the patient is on a 1800 calorie diet and that was what should be on the plan of care.	G 574			
G 580	17-13-1(a)(1)(D)(ix) Only as ordered by a physician CFR(s): 484.60(b)(1)  Drugs, services, and treatments are administered only as ordered by a physician. This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure orders were obtained by a physician in 2 of 5 active clinical records reviewed, out of a total of 9 clinical records reviewed. (#3, #7)  The findings include:  1. Record review evidenced an agency policy titled "Physician Verbal and Telephone Orders"	G 580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 580	<p>Continued From page 43</p> <p>dated 1/14/2018, which stated, "Purpose to obtain conformation for a change in treatment, medication, services, continuation of services (recertification) and stare [sic] when indicated ...</p> <p>3. Notifying physicians of laboratory results and other significant changes are documented as an FYI [for your information] on the physician order form 4. The clerk will make a second request for Physician Orders not returned with a physician signature in fourteen (14) days ...."</p> <p>2. Record review evidenced an undated agency policy titled "Medications," which stated, " ... b. Drugs and medications are administered by staff only as ordered by the physician ... Drugs and medications are administered by staff only as ordered by the physician ... h. Insulin syringes will be pre-filled weekly for diabetic patients who require filling of syringes when indicated and prescribed by the physician ...."</p> <p>3. Record review evidenced an agency policy titled "Registered Nurse" dated 1/14/2018, which stated, " ... 8. Consults with the physician and ensures that physician orders for change in service and/or treatment are submitted to the physician for signature ...."</p> <p>4. Record review on 1/19/2021, evidenced an agency policy titled, "Skilled Professional Services", dated 1/14/2018. This policy stated, "Skilled professional service providers assume the following responsibilities ... c. Providing services that are ordered by the physician...."</p> <p>5. Record review evidenced an undated agency policy titled, "Wound Care", which stated, " ... Policy: 1. The patient's physician order will be followed to treat all wounds. 2. No treatment will</p>	G 580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 580	<p>Continued From page 44</p> <p>be applied to any wound without a physician order...."</p> <p>6. Clinical record review on 1/19/2021 for patient #3, evidenced an agency document titled "Telephone Orders" dated 12/18/2020 and signed by the clinical manager. This document stated "Per [Person Q, Pharmacist from Entity L] increase insulin to 25 units per day. Decrease to 20 units for hypoglycemia [low blood sugar] levels." This order was a verbal order from person Q [pharmacist], not from a physician. This order failed evidence it was initiated by the patient's physician.</p> <p>During a home visit for patient #3 on 1/14/2021 at 11:28 a.m., employee C, RN was observed calling and speaking to person Q, [pharmacist from entity L]. Employee C discussed patient #3's blood sugar levels and eating habits with person Q. Person Q educated patient #3 on better eating habits, while on speaker phone, and changed patient #3's insulin order to increase the evening insulin [for high blood sugar] from 8 units to 10 units. Employee C wrote the new order in her notes and educated patient on his new insulin orders. Employee C failed to speak with a physician about this insulin change.</p> <p>During an interview on 1/20/2021 at 10:40 a.m., the clinical manager stated, "At the VA the pharmacist manages the diabetic medication and other medications, there should be a copy of the order sent to the physician, but he never sends it back."</p> <p>7. Clinical record review on 1/19/2021 for patient #7, with start of care 4/1/2020, and certification period 9/28/2020 to 11/26/2020, evidenced a</p>	G 580			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 580	<p>Continued From page 45</p> <p>document from entity L, titled "Home Wound Care Instructions", dated 9/24/2020, and signed by the physician, which stated, " ... Instructions: Please change left heel wound dressing 3x/week [3 times per week]. Apply Prisma Ag [a wound dressing with collagen] to wound, wrap with 4 x 4 gauze, webril [a cotton padding] and Kerlix [a rolled woven gauze]...."</p> <p>Clinical record review evidenced an agency document titled, "Skilled Nursing Note", dated 10/12/2020, and signed by employee I, LPN [licensed practical nurse]. This note stated, " ... Dressing change procedure: Cleanse L [left] heel apply alginate [a wound dressing derived from seaweed] to Prisma wound bed wrap with Webril, Kerlix, Abd pad [a gauze pad]...." The skilled nurse failed to provide wound care as ordered by the physician.</p> <p>Clinical record review evidenced a document from entity L, titled "Home Wound Care Instructions", dated 10/22/2020, and signed by the physician, which stated, " ... Instructions: Apply Iodosorb [an antimicrobial wound gel] to 3rd toe blister (Abrasion R [right] foot) 2) Continue L [left] heel wound care with Prisma [a wound dressing with collagen] and / or Keracel Ag [a gelling fiber dressing]; cleanse with saline cover with sterile dressing...."</p> <p>Clinical record review of a skilled nursing note dated 10/24/2020, signed by employee I, LPN, stated, "Dressing change procedure: Apply Iodosorb to 3rd R [right] toe abrasion R [right] foot Cleanse with NS [normal saline]cover L [left] heel wound with Prisma and/or Kertroz Ag [sic]. Cover with sterile dressing...."</p>	G 580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 580	<p>Continued From page 46</p> <p>Review of a skilled nursing note dated 10/26/2020, signed by employee I, stated, "Dressing change procedure: Cleanse L [left] heel with NS Apply Prisma or / and Kerteszag [sic] cover with sterile dressing Apply Iodosorb to 3rd toe abrasion on R [right] Foot...."</p> <p>Review of a skilled nursing note dated 10/28/2020, signed by employee I, stated, "Dressing change procedure: Cleanse L Heel with NS pat dry apply prisma / or Kertesz Ag [sic] cover with sterile dressing. Apply Iodosorb to 3rd toe R Foot...."</p> <p>Review of a skilled nursing note dated 10/31/2020, signed by employee I, stated, "Dressing change procedure: Cleanse with NS pat dry apply prisma or Kertesz Ag [sic] to L Heel, cover with sterile dressing. Apply Iodosorb to 3rd toe R Foot...."</p> <p>Review of skilled nursing notes dated 11/2/2020, 11/4/2020, 11/6/2020, 11/9/2020, 11/11/2020, 11/13/2020, 11/21/2020, 11/23/2020 and 11/25/2020 signed by employee I, each stated, "Dressing change procedure: Cleanse with NS pat dry apply Prism [sic] / Kertel [sic] to site cover with 4 x 4 apply webril [a cotton padding] wrap with kerlix [a rolled woven gauze] secure with tape...."</p> <p>Review of a skilled nursing note dated 11/16/2020, signed by employee I, stated, "Dressing change procedure: Cleanse NS pat dry apply prism or Alt. to wound bed cover with 4 x 4 apply webril and Kerlix secure with tape...."</p> <p>During an interview on 1/20/2021 at 1:57 p.m., the administrator indicated the dressing change</p>	G 580			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 580	Continued From page 47 procedure should evidence what wound care supplies were used by the nurse. The administrator indicated the nurse failed to clearly document the wound care.  During an interview on 1/20/2021 at 1:57 p.m., the administrator stated "it is an error", in regards to the skilled nurses wound care documentation. The administrator indicated alginate was not ordered to be used for this patient.	G 580			
G 584	17-13-1(a) Verbal orders CFR(s): 484.60(b)(3)(4)  (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies.  (4) When services are provided on the basis of a physician's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician in accordance with applicable state laws and regulations, as well as the HHA's internal policies. This ELEMENT is not met as evidenced by: Based on clinical record review and interview, the home health agency failed to ensure verbal orders were signed by the physician in 1 out of 1 clinical records reviewed with insulin orders. (#3)	G 584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 584	Continued From page 48 The findings include:  1. Record review evidenced an agency policy titled "Physician Verbal and Telephone Orders" dated 1/14/2018, which stated, "Purpose to obtain conformation for a change in treatment, medication, services, continuation of services (recertification) and stare [sic] when indicated ... 3. Notifying physicians of laboratory results and other significant changes are documented as an FYI [for your information] on the physician order form 4. The clerk will make a second request for Physician Orders not returned with a physician signature in fourteen (14) days ...."  2. Record review evidenced an undated agency policy titled "Medications," which stated, " ... b. Drugs and medications are administered by staff only as ordered by the physician ... Drugs and medications are administered by staff only as ordered by the physician ... h. Insulin syringes will be pre-filled weekly for diabetic patients who require filling of syringes when indicated and prescribed by the physician ...."  3. Record review evidenced an agency policy titled "Registered Nurse" dated 1/14/2018, which stated, " ... 8. Consults with the physician and ensures that physician orders for change in service and/or treatment are submitted to the physician for signature ....  4. Clinical record review on 1/19/2021 for patient #3, evidenced an agency document titled "Telephone Orders" dated 12/18/2020 and signed by the clinical manager. This order stated "Per VA [veterans administration] [person Q], increase insulin to 25 units per day. Decrease to 20 units for hypoglycemia levels." This verbal order failed	G 584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 584	Continued From page 49 to be initiated and signed by the physician.  During an interview on 1/20/2021 at 10:40 a.m., the clinical manager stated, "At the VA the pharmacist manages the diabetic medication and other medications, there should be a copy of the order sent to the physician, but he never sends it back."	G 584			
G 590	17-14-1(a)(1)(H) Promptly alert relevant physician of changes CFR(s): 484.60(c)(1)  The HHA must promptly alert the relevant physician(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 promptly alert the physician to changes in the needs or conditions of patients in 6 of 9 clinical records reviewed. (#2, #3 #4, #5, #8, #9)  The findings include:  1. Record review evidenced an agency policy titled "Registered Nurse" dated 1/14/2018, which stated, " ... c. The home health aide is required to notify the nurse of any changes to the patient's condition ... 7. Coordinates services b. reviews the medical record for completeness. 8. Consults with the physician and ensures that physician orders for change in services and/or treatment are submitted to the physician for signature ...."  2. Record review evidenced an agency policy	G 590			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 590	<p>Continued From page 50</p> <p>titled "Physician Verbal and Telephone Orders" dated 1/14/2018, which stated, "Purpose to obtain conformation for a change in treatment, medication, services, continuation of services (recertification) and stare [sic] when indicated ...</p> <p>3. Notifying physicians of laboratory results and other significant changes are documented as an FYI [for your information] on the physician order form 4. The clerk will make a second request for Physician Orders not returned with a physician signature in fourteen (14) days ...."</p> <p>3. Record review evidenced an undated agency policy titled "Plan of Treatment" which stated, " ...</p> <p>b. Home health agency personnel shall promptly notify a patient's physician or other appropriate medical personnel and guardian, if any, or [sic] any significant physical or mental changes observed or reported by the patient. In the care of medical emergency, the home health agency will know in advance which emergency systems contact ...."</p> <p>4. Clinical record review on 1/19/2021 for patient #4 start of care 10/4/2017, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE, for certification period 7/20/2020 to 9/17/2020, signed by employee C, RN [Registered Nurse] and physician I, MD. This document had a subsection titled "Orders for Discipline and Treatments" which stated "report s/sx [signs/symptoms] necessitating medical attention to the physician ... Notify physician of B/P &gt; [greater than 160/90 &lt; [less than] 90/60, pulse rate &gt; 100 &lt; 60 ...."</p>	G 590			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 590	<p>Continued From page 51</p> <p>Clinical record review on 1/19/2021 for patient #4 evidenced an agency document titled "Comprehensive Adult Assessment," dated 4/14/2020 and signed by employee C, RN. This document had a subsection titled "Respiratory Status" which stated, "pt [patient] coughs when drinking liquids." This document failed to evidence employee C notified the physician of the patient's coughing when drinking liquids</p> <p>Clinical record review on 1/19/2021 for patient #4 evidenced an agency document titled "Skilled Nursing Note," dated 4/24/2020 and signed by employee I, LPN [licensed practical nurse] which stated, "B/P [blood pressure 80/59." This document failed to evidence employee I notified the physician of the patient's low blood pressure.</p> <p>Clinical record review on 1/19/2021 for patient #4 evidenced an agency document titled "Skilled Nursing Note", dated 4/28/2020 and signed by employee I, LPN which stated, "B/P [blood pressure 80/60." This document failed to evidence employee I notified the physician of the patient's low blood pressure.</p> <p>Clinical record review on 1/19/2021 for patient #4 start of care 10/4/2017 evidenced an agency document titled "Skilled Nursing Note," dated 5/15/2020 and signed by employee C, RN [registered nurse] which stated, "B/P [blood pressure 83/62." This document failed to evidence employee C notified the physician of the patient's low blood pressure.</p> <p>Clinical record review on 1/19/2021 for patient #4 start of care 10/4/2017 evidenced an unsigned agency document titled "Narrative Note," dated 7/14/2020 which stated, "Pt [patient] has not been</p>	G 590			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 590	<p>Continued From page 52</p> <p>eating. Pt has been drinking ensure ... Pt has noted weight loss." This document failed to evidence the physician was notified patient #4 was not eating and had weight loss.</p> <p>During an interview on 1/20/2021 at 3:12 p.m., the clinical manager indicated the physician was not called about the low blood pressure or the weight loss if there was not documentation in the chart.</p> <p>5. Clinical record review on 1/19/2021 for patient #9, start of care 6/3/20 evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 10/1/2020 to 11/29/2020. This document had a subsection titled "Orders for Discipline and Treatments," which stated "SN 1-2 x week 9. [1-2 times a week for 9 weeks] Assess VS [vital signs] and all body systems, med [medication] knowledge and complication, knowledge r/t [related to] tx [treatment] and dx [diagnosis]/care regimen and safety of client/environment and report s/sx [signs/symptoms] necessitating medical attention to the physician ...."</p> <p>Clinical record review for patient #9 evidenced an agency document titled "Skilled Nursing Note," signed by employee C, RN and dated 11/2/2020. This document had a subsection titled "LEVEL OF PAIN," which stated, "Rates left anterior leg pain 10 on 0-10 scale. [where 0 is no pain and 10 is the most severe pain] ...." This document failed to evidence the physician was notified of the patient's severe pain.</p> <p>Clinical record review for patient #9 evidenced an</p>	G 590			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 590	<p>Continued From page 53</p> <p>agency document titled "Skilled Nursing Note," signed by employee C, RN and dated 11/6/2020. This document had a subsection titled "LEVEL OF PAIN," which stated, "left anterior leg pain 10 on 0-10 pain scale. This document failed to evidence the physician was notified of the patient's severe pain.</p> <p>Clinical record review for patient #9 evidenced an agency document titled "Skilled Nursing Note," signed by employee C, RN and dated 10/12/2020. This document had a subsection titled "INTERVENTION," which stated, "pt [patient] wt [weight 211 lbs (pounds)] was 205 lbs ... awaiting response ....." This document failed to evidence the physician was aware of the patient's weight gain.</p> <p>Clinical record review for patient #9 evidenced an agency document titled "Skilled Nursing Note," signed by employee C, RN and dated 10/9/2020. This document had a subsection titled "INTERVENTION," which stated, "pt was 205 now 211 pt has +2-3 edema [swelling] to left leg ... awaiting call from physician's office ....." This document failed to evidence the physician was aware of the patient's weight gain and edema.</p> <p>Clinical record review for patient #9 evidenced agency documents titled "Skilled Nursing Note," signed by employee C, RN and dated 10/26/2020, 10/28/2020, and 10/20/2020 . These documents had a subsection titled "CARDIOVASCULAR," which stated, "RLE [right lower extremity] +2 [referencing edema (swelling)] LLE [left lower extremity] +3 [referencing (swelling)]...." These documents failed to evidence the physician was notified of the patient lower leg edema.</p>	G 590			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 590	Continued From page 54  Clinical record review for patient #9 evidenced agency documents titled "Skilled Nursing Note," signed by employee C, RN and dated 10/5/2020, 10/7/2020, 10/9/2020 10/12/2020, 10/14/2020, 10/19/2020, 10/21/2020, 10/23/2020, 11/2/2020, 11/4/2020, 11/6/2020, 11/11/2020, 11/16/2020, 11/18/2020, 11/19/2020, 11/20/2020, 11/23/2020, and 11/27/2020. These documents had a subsection titled "CARDIOVASCULAR," which stated, "RLE +2 [referencing edema (swelling)] LLE +3 [referencing edema (swelling)]...." These documents failed to evidence the physician was notified of the patient's bilateral lower leg edema.  During an interview on 1/20/2021 at 3:41 p.m., the clinical manager indicated the physician was called about the patient's increased weight gain. They just never received a call back. Review of the clinical record failed to evidence documentation the agency had called the physician. The clinical manager indicated the physician was aware of the patient's edema. When queried as to whether the physician was notified of the patient's severe pain, she stated "if there is intolerable pain and pain meds are not holding then the physician would be notified." No further documentation was provided as of end of survey dated 1/20/2020.  6. Clinical Record review on 1/19/2021 for patient #5, start of care 4/11/2017, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 11/27/2019 to 1/25/2020, signed by employee A, RN. This document had an area subtitled "Orders for Discipline and Treatments" which stated " SN 1-2 x week 9	G 590			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 590	<p>Continued From page 55</p> <p>Assess all VS [Vital Signs] and all body systems, med knowledge and complications ... Assess medication compliance/med set-up Notify physician of blood pressure &gt; 160/90 and &lt; 90/60 and pulse rate &gt;100 &lt; 60. Instruct patient on diabetic care to include diet, activity, stress, foot care, skin care, s/s of complication of diabetes, s/s hyper/hypo glycemia [high/low blood sugar] monitor glucometer readings for variations and compliance ...."</p> <p>Clinical Record review on 1/19/2021 for patient #5 evidenced an agency document titled "Narrative Note," dated 1/20/2020 which stated " ... [Patient #5] is not able to independently monitor his glucose." This document failed to evidence the physician was notified patient #5 could not monitor his glucose level.</p> <p>Clinical Record review on 1/19/2021 for patient #5 evidenced agency document titled "Narrative Note," dated 1/20/2020 and signed by employee A, RN which stated, " ... He stated Alexa [voice assistant] did not remind him of his medications last night or this morning. He has not taken his medications this morning still in bed." This document failed to evidence the physician was notified patient #5 did not take his medications.</p> <p>Clinical record review on 1/19/2021 for patient #5 evidenced an agency document titled "Skilled Nursing Note," signed by employee A, RN and dated 1/3/2020. This document had an area subtitled "Data" which stated, "Has received Urea cream and Lidocaine has not used ... non-compliant with medications based on mediplanner ... would not attempt to test his glucose level ...." This document failed to evidence the physician was notified the patient</p>	G 590			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 590	<p>Continued From page 56</p> <p>was not using his medication or willing to test his blood glucose level.</p> <p>Clinical record review on 1/19/2021 for patient #5, evidenced an agency document titled "Skilled Nursing Note," signed by employee A, RN and dated 1/10/2020. This document had an area subtitled "Data" which stated, "Pt more than likely not monitor his blood sugar ...." This document failed to evidence the physician was notified of the patient's unwillingness to monitor his blood glucose.</p> <p>During an interview on 1/20/2021 at 11:40 a.m., the clinical manager indicated the physician was aware the patient would not monitor his blood sugar, it just was not documented.</p> <p>Clinical record review on 1/19/2021 for patient #5, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 11/27/2019 to 1/25/2020, which was signed by the clinical manager and dated 12/20/19. This document had a subsection titled, "Medications," which stated, "... Metformin 1000 mg [milligrams] one tablet BID [twice daily] before meals ...."</p> <p>Clinical record review on 1/19/2021 for patient #5, evidenced an agency document titled "Skilled Nursing Note," signed by employee A, RN and dated 1/17/2020. This document had an area subtitled "Data" which stated, "Metformin tablets have been cut in half ... unable to monitor glucose level without assistance ... not compliant with medications ...." This document failed to evidence the physician was notified of the patient receiving the wrong dose of medication, unable to monitor glucose levels, and</p>	G 590			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 590	<p>Continued From page 57</p> <p>not taking medications as prescribed by his primary care physician.</p> <p>During an interview on 1 /20/2021 at 11:23 a.m., the clinical manager indicated the physician was notified patient #5 was non-compliant with medications and was unable to monitor his blood sugar, but it was not documented in the chart.</p> <p>Clinical record review on 1/19/2021 for patient #5, evidenced an agency document titled "Skilled Nursing Note," signed by employee A, RN and dated 2/4/2020. This document had an area subtitled "Data" which stated, "Med planner spilled pills missing and out of order ...." This document failed to evidence the physician was notified the skilled nurse found the patient's medication had spilled out of the mediplanner and were out of order.</p> <p>During an interview on 1/20/2021 at 11:49 a.m., the clinical manager indicated the physician was not notified the pills had been spilled out of the mediplanner and where placed back in the mediplanner out of order.</p> <p>7. Clinical record review on 1/19/2021 for patient #8, start of care 8/21/2020, evidenced an agency document titled "Medication Profile" which stated, "... hydrochlorothiazide [for high blood pressure] 25 mg Q day PO hypertension (pt unable to locate VA mailed 90 last month) ...." This document failed to evidence the physician was notified of the lost medication and did not have any in the home.</p> <p>During an interview on 1/20/2021 at 1:50 p.m., the clinical manager indicated they called the patient's pharmacy that is how they knew 90 pills</p>	G 590			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 590	<p>Continued From page 58 were sent the month before.</p> <p>8. Clinical record review on 1/19/2021 for patient #3 start of care 12/2/2020, evidenced agency documents titled "Skilled Nursing Note" signed by employee C, RN, dated 10/23/2020, 10/20/2020, and 10/27/2020. These documents had a subsection titled "Data" which stated " ... noncompliant with noon medications ...." These documents failed to evidence the physician was notified the patient was not taking medications at noon as prescribed by the primary care physician.</p> <p>Clinical record review on 1/19/2021 for patient #3, start of care 12/2/2020, evidenced an agency document titled "Skilled Nursing Note" signed by employee C, RN, dated 11/14/2020. This document had a subsection titled "Data" which stated, " ... noncompliant with noon medications per medication planner ...." This document failed to evidence the physician was notified the patient was not taking his medications as prescribed by his primary care physician.</p> <p>Clinical record review on 1/19/2021 for patient #3, start of care 12/2/2020, evidenced an agency document titled "Skilled Nursing Note" signed by employee C, RN, and dated 11/20/2020. This document had a subsection titled "Data" which stated, "noncompliant with noon medications ...." This document failed to evidence the physician was notified the patient was not taking his medications as prescribed by his primary care physician.</p> <p>Clinical record review on 1/19/2021 for patient #3, start of care 12/2/2020, evidenced an agency document titled "Skilled Nursing Note" signed by employee C, RN, and dated 11/24/2020. This</p>	G 590			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 590	<p>Continued From page 59</p> <p>document had a subsection titled "Data" which stated, "noncompliant with noon and evening medications ...." This document failed to evidence the physician was notified the patient was not taking his medications as prescribed by his primary care physician.</p> <p>Clinical record review on 1/19/2021 for patient #3, start of care 12/2/2020, evidenced an agency document titled "Skilled Nursing Note" signed by employee C, RN, and dated 11/27/2020. This document had a subsection titled "Data" which stated, "noncompliant with noon medications ...." This document failed to evidence the physician was notified the patient was not taking medications as prescribed by his primary care physician.</p> <p>Clinical record review on 1/19/2021 for patient #3, start of care 12/2/2020, evidenced an agency document titled "Skilled Nursing Note" signed by employee C, RN, and dated 12/1/2020. This document had a subsection titled "Data" which stated, "noncompliant with evening medications ...." This document failed to evidence the physician was notified the patient was not taking medications as prescribed by his primary care physician.</p> <p>Clinical record review on 1/19/2021 for patient #3 start of care 12/2/2020, evidenced an agency document titled "Skilled Nursing Note" signed by employee C, RN, and dated 11/17/2020. This document had a subsection titled "Data" which stated, "noncompliant with noon medications per medication planner ...." This document failed to evidence the physician was notified the patient was not taking medications as prescribed by his</p>	G 590			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 590	<p>Continued From page 60 primary care physician.</p> <p>Clinical record review on 1/19/2021 for patient #3 evidenced an agency document titled "Skilled Nursing Note" signed by employee C, RN, and dated 11/3/2020 This document had a subsection titled "Data" which stated, "noncompliant with noon medications ...." This document failed to evidence the physician was notified the patient was not taking medications as prescribed by his primary care physician.</p> <p>Clinical record review on 1/19/2021 for patient #3 evidenced agency documents titled "Skilled Nursing Note" signed by employee C, RN, and dated 11/6/2020 and 11/10/2020. These documents had a subsection titled "Data" which stated, "noncompliant with noon medications per planner...." These documents failed to evidence the physician was notified the patient was not taking medications as prescribed by his primary care physician.</p> <p>During an interview on 1/20/2021 at 10:40 a.m., the administrator indicated the physician was aware of patient #3's noncompliance with his medications, it just was not documented.</p> <p>9. Clinical record review on 1/19/2021 for patient #2, with start of care 9/24/2019 and certification period 11/17/2020 to 1/15/2021, evidenced a group of agency documents titled "Skilled Nursing Note". Review of a skilled nursing note dated 11/25/2020, indicated the patient's blood pressure</p>	G 590			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 590	Continued From page 61 was 80/60. This note failed to evidence the skilled nurse notified the physician of the low blood pressure. A note dated 12/16/2020, indicated the patient's blood pressure was 78/63. This note also failed to evidence the skilled nurse notified the physician of the patient's low blood pressure.  During an interview on 1/20/2021 at 11:09 a.m., the administrator indicated the nurse failed to notify the physician on each occurrence and document this communication in the skilled nurse visit notes.	G 590			
G 606	17-13-1(a)(2) Integrate all services CFR(s): 484.60(d)(3)  Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. This ELEMENT is not met as evidenced by: Based on record review and interview, the home health agency failed to integrate services to ensure coordination of care provided by all disciplines and outside healthcare entities who serviced their patients in 3 of 6 active clinical records reviewed, out of a total sample of 9 clinical records reviewed. (#2, #5, #8)  The findings include:  1. Record review on 1/19/2021, evidenced an agency policy titled "Skilled Professional	G 606			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 606	<p>Continued From page 62</p> <p>Services", dated 1/14/2018. This policy stated, " ... Skilled professional service providers assume the following responsibilities ... f. Communication with al [sic] physicians involved in the plan of care and other health care practitioners as appropriate related to the current plan of care...."</p> <p>2. Clinical record review on 1 /29/2021 for patient #5, start of care 4/11/2017, evidenced an agency document titled, "Narrative Note," dated 4/30/2020 and signed by the clinical manager. This document stated, " ... Received a call from [person O, from entity P (hospital)] informed her I am unable to get a hold of Entity N [home health care], she stated she would try to get a hold of them ...." Record review failed to evidence coordination of care with entity N.</p> <p>Clinical record review on 1 /29/2021 for patient #5, start of care 4/11/2017 evidenced an agency document titled, "Narrative Note," dated 4/30/2020 and signed by the clinical manager. This document stated, " ... Has homemaker services visiting today ...." Record review failed to evidence coordination of care with entity N.</p> <p>Clinical record review on 1/29/2021 for patient #5, start of care 4/11/2017 evidenced an agency document titled, "Narrative Note," dated 4/30/2020 and signed by the clinical manager and employee I, LPN which stated, " ... Client receives home maker services ...." Record review failed to evidence coordination of care with entity N.</p> <p>During an interview on 1/21/2021 at 11:24 p.m., the clinical manager indicated there was no coordination of care with Entity N. The services</p>	G 606			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 606	<p>Continued From page 63</p> <p>were set up by the VA [Veteran's Association] and Entity N would not share any information with the agency.</p> <p>3. Clinical record review on 1/19/2021 for patient #8, start of care 8/21/2020, evidenced an agency document titled "Narrative Note. This document stated, "PT [physical therapy] missed visit 11/24/20 Patient canceled PT due to medical surgical procedure. PT rescheduled for 11/27/2020 PT missed visit 11/27/20 Pt [patient] canceled PT due to medical surgical/ procedure. PT rescheduled for 12/1/2020."</p> <p>Clinical record review on 1/19/2021 for patient #8, start of care 8/21/2020, evidenced an agency document titled "Case Conference Note" dated 11/23/2020 and signed by the clinical manager, employee I. LPN and employee C. RN. This document stated, "no recent falls [patient #8 states she is losing weight because of physical therapy] [patient #8's] ability to manage her medications is limited she is compliant with weekly set up." The agency failed to ensure coordination of care between agency disciplines.</p> <p>During an interview on 1/20/2021 at 1:47 p.m., the clinical manager indicated she was unaware patient #8 missed visits due to a surgical procedure. The clinical manager remained silent when queried as to whether there was coordination of care between the agency disciplines for patient #8.</p> <p>4. Clinical record review on 1/19/2021 for patient #2, with start of care 9/24/2020, and certification period 11/17/2020 to 1/15/2021, evidenced two documents from entity E. These documents were</p>	G 606			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 606	Continued From page 64 identified by the administrator as wound clinic notes, dated 11/23/2020 and 12/21/2020.  During an interview on 1/20/2021 at 11:09 a.m., the administrator indicated the agency coordinated care with the wound clinic by receiving the wound clinic notes. The administrator indicated the patient was ordered to go to the wound clinic weekly. When queried if additional wound clinic notes were available for 11/17/2020 to 1/15/2021, the administrator stated, "No, those are the only two times she went".  During an interview on 1/22/2021, person F, an employee of entity E, indicated the patient had been treated at the wound clinic 11/23/2020, 12/7/2020, and 12/21/2020.  There failed to be evidence in the clinical record of coordination of care between Entity E and the home health agency.	G 606			
G 610	17-12-2(h) Patients receive education and training CFR(s): 484.60(d)(5)  Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge.  This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure each patient and his or her caregiver received ongoing education and training in 3 of 3 clinical records of patients who	G 610			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 610	<p>Continued From page 65</p> <p>were blind, out of a total sample of 9 records reviewed. (#6, #7, #9)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Record review on 1/19/202, evidenced an agency policy titled "Plan of Treatment - 485", dated 1/14/2018, which stated, "Policy: ... 4. The individualized plan of care also specifies the patient caregiver education and training...."</li> <li>Record review evidenced an agency policy titled "Patient Rights", dated 1/14/2018, which stated, " ... Information will be provided to patients in plain language and in a manner that is accessible and timely to persons with disabilities...."</li> <li>Clinical record review on 1/19/2021 for patient #6, with start of care 6/17/2019 and certification period 10/9/2020 to 12/7/2020, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". This plan of care evidenced a subcategory titled "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)" which stated, " ... Instruct patient on diabetic care to include diet, activity, stress, foot care, skin care, S/S [signs and symptoms] of complication of diabetes, S/S of hypo / hyperglycemia [low or high blood sugar] ... Psychosocial: [patient #6] is blind requires assistance with all activities of daily living. He lives with his supportive sister who is employed. [Patient #6] is unable to identify an emergency...."</li> </ol> <p>Clinical review of the plan of care evidenced a subcategory titled, "Other Pertinent Diagnoses" which stated, " ... Blindness, both eyes...."</p>	G 610			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 610	<p>Continued From page 66</p> <p>Clinical record review evidenced a group of agency documents titled "Skilled Nursing Note", dated 10/12/2020, 10/26/2020, 11/2/2020, 11/9/2020, 11/16/2020, 11/23/2020, and 11/30/2020. Each of these notes failed to evidence education and training included the patient's caregiver.</p> <p>During an interview on 1/20/2021 at 12:15 p.m., the administrator indicated the patient was "not a good learner". When queried if the caregiver was included in patient education and training, the administrator did not respond.</p> <p>4. Clinical record review on 1/19/2021 for patient #7, with start of care 4/1/2020 and certification period 9/28/2020 to 11/26/2020, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". This document had a subcategory titled, "Other Pertinent Diagnoses" which stated, "Unspecified dementia without behavioral dis [disturbance] [a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems] ... Blindness, both eyes...."</p> <p>Clinical record review of the patient's plan of care evidenced a subcategory titled, "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)" which stated, " ... Instruct patient on diabetic care to include diet, activity, stress, foot care, skin care, S/S [signs and symptoms] of complication of diabetes, S/S of hypo / hyperglycemia [low or high blood sugar]...."</p> <p>Clinical record review of a skilled nursing note dated 11/16/2020, signed by employee I, LPN [licensed practical nurse], stated " ... Instruct client to monitor exp [expiration] date on</p>	G 610			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 610	Continued From page 67 insulin...."  Clinical record review evidenced a group of agency documents titled "Skilled Nursing Note", dated 9/28/2020, 9/30/2020, 10/3/2020, 10/7/2020, 10/10/2020, 10/12/2020, 10/14/2020, 10/16/2020, 10/19/2020, 10/21/2020, 10/24/2020, 10/26/2020, 10/28/2020, 10/31/2020, 11/2/2020, 11/4/2020, 11/6/2020, 11/9/2020, 11/11/2020, 11/13/2020, 11/16/2020, 11/18/2020, 11/21/2020, 11/23/2020 and 11/25/2020. Each of these notes failed to evidence education and training included the patient's caregiver.  During an interview on 1/20/2021 at 2:30 p.m., the administrator indicated due to dementia, the patient was not able to learn about diabetic care. The administrator also indicated the patient was blind, unable to perform foot care or skin care, and unable to read an insulin vial. The administrator indicated the agency failed to ensure the patient's caregiver received education and training.  5. Clinical record review on 1/19/2021 for patient #9, start of care 6/30/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 10/1/2020 to 11/29/2020, signed by the clinical manager and dated 9/30/2020. Patient #9 diagnoses included, but was not limited to, Hypertension [high blood pressure] diabetes [high blood sugar] heart	G 610			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 610	<p>Continued From page 68</p> <p>disease, hyperlipidemia [high cholesterol] and gastro-esophageal reflux disease. This document had a subsection titled "Orders for Discipline and Treatment" which stated "SN [skilled nurse] 1-2 x week 9 Assess all VS [Vital Signs] and all body systems, med knowledge and complication, knowledge r/t [related to] tx [treatment] dx [diagnosis]/care regimen and safety of client/environment and report s/s [signs/symptoms] necessitating medical attention to the physician, Implement and Instruct Universal Precautions/Infection Control. Implement and instruct medication regimen including dosage, side effects, name, route, frequency, desired action and adverse side reactions. Assess medication compliance/med set-up Notify physician of blood pressure &gt; 160/90 and &lt; 90/60 and pulse rate &gt;100 &lt; 60. Instruct patient on diabetic care to include diet, activity, stress, foot care, skin care, s/s of complication of diabetes, s/s hyper/hypo glycemia [high/low blood sugar] monitor glucometer readings for variations and compliance. Glucometer testing to be performed by patient Q [every] day. Notify physician of blood sugar over 300 and under 60. Assess respiratory status. Daily normal saline wet to dry dressing change to left leg. Instruct patient on wound care procedure to be performed 4-5 x [times] week ...."</p> <p>Clinical record review on 1/19/2021 for patient #9, evidenced agency documents titled "Skilled Nursing Visit" signed by employee C, RN, and dated 10/9/2020, 10/12/2020, and 11/19/2020. These skilled nursing visit notes failed to evidence any teaching / education provided to the patient.</p> <p>During an interview on 1/20/2021 at 3:55 p.m.,</p>	G 610			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 610	Continued From page 69 the clinical manager indicated teaching is done every visit it just was not documented on these nursing visit notes.	G 610			
G 614	17-14-1(a)(1)(G) 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 their patients received a written visit schedule in 2 of 3 home visits conducted. (#2, #3)  The findings include:  1. Record review on 1/19/2021, evidenced an agency document titled "Patient Rights", dated 1/14/2018, which stated, " ... The patient has the right to: ... d. Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to ... ii. The care to be furnished, based on the comprehensive assessment ... v. The frequency of visits...."  2. Observation of a home visit for patient #2 on 1/15/2021 at 12:58 p.m., failed to evidence a written visit schedule of services to be provided from the home health agency.  During an interview on 1/15/2021 at 1:29 p.m., patient #2 indicated she had not received a written visit schedule from the agency.	G 614			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 614	Continued From page 70  During an interview on 1/20/2021 at 11:11 a.m., the administrator indicated the agency failed to ensure the patient received a written visit schedule.  3. Observation during a home visit on 1/14/2021 at 10:35 a.m., for patient #3, failed to evidence a home visit schedule from the home health agency for services to be provided.  During an interview on 1/14/2021 at 10:55 a.m., patient #3 indicated the agency calls him but he does not have a written schedule provided by the agency in his home.  During an interview on 1/21/2021 at 3:15 p.m., the clinical manager indicated there was not a home visit schedule in the home for patient #3.	G 614			
G 616	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, record review and interview, the agency failed to ensure patients were provided a current written patient medication list in 2 of 3 home visits conducted (#1, #3)  The findings include:  1. Observation of a home visit for patient #1 on 1/13/2021 at 8:00 a.m., failed to evidence a	G 616			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 616	<p>Continued From page 71</p> <p>current patient medication list provided by the home health agency.</p> <p>During an interview on 1/13/2021 at 9:25 a.m., person D, caregiver to patient #1, indicated the home health agency had not provided them a current patient medication list.</p> <p>During an interview on 1/15/2021 at 4:18 p.m., the administrator indicated the agency failed to ensure patients were provided a current written list of their medications.</p> <p>2. Clinical record review on 1/20/2021 for patient #3, start of care 12/2/2019, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 9/27/2020 to 11/25/2020, signed by employee C, RN. This document had a subsection titled "MEDICATIONS: Dose/Frequency/Route," which stated benzonatate [for cough] 100 mg TID PO PRN [three (3) times a day by mouth as needed] ... Aspirin 81 mg EC [enteric coated] Q [every day] day PO [by mouth]..."</p> <p>During a home visit on 1/14/2021 at 10:32 a.m., an observation was made of a current medication list for patient #3. This medication listed stated, "benzonatate [for cough] 100 mg [milligram] 3 times a day ...." The medication list failed to evidence patient #3's order for Aspirin and failed to evidence benzonatate was to be used as needed.</p> <p>During an interview on 1/19/2021 at 10:41 a.m., the clinical manager indicated the correct</p>	G 616			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 616	Continued From page 72 medications are put in the patients medi planner by the nurse. When notified of the concern of the medications on the patients list in the home, the clinical manager remained silent.	G 616			
G 682	Infection Prevention CFR(s): 484.70(a)  Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to follow accepted standards of practice for infection control in 2 of 3 home visits conducted. (#1, #3)  The findings include:  1. Record review on 1/19/2021, evidenced an undated agency policy titled "Infection Control". This policy stated, "Purpose: To establish guidelines for preventing, identifying and controlling infections among patients, caregivers, staff and the community. 1. Policy: a. The implementation of the Universal Blood and Body fluid precaution guidelines are mandatory requirements to prevent the spread of infections...."  2. Record review evidenced an agency policy titled "Universal Precautions", dated 1/14/2018. This policy stated " ... Surfaces and equipment contaminated with blood or potentially infectious material that need not be sterilized are cleaned and disinfected after treatment...."	G 682			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 682	<p>Continued From page 73</p> <p>3. Record review evidenced an agency policy titled "Home Health Aide Services", dated 1/14/2018. This policy stated, " ... A home health aide competency training program must address each of the following areas: ... iv. Basic infection prevention and control procedures ... vi. Maintenance of a clean, safe, and healthy environment ... Appropriate and safe techniques in performing personal hygiene and grooming tasks that include: 1. Bed bath..."</p> <p>4. During a home visit for patient #1 on 1/13/2021 at 8:04 a.m., employee J, HHA [home health aide] was observed performing a bed bath on the patient. At 8:07 a.m., the HHA brought a basin of water, towels, and 2 washcloths, one blue and one white, into the patient's room. At 8:37 a.m., after bathing patient's upper body, the HHA emptied the water from the bath basin, rinsed and refilled the basin with water, placed both washcloths in the basin, and continued to bathe the patient with the same 2 washcloths. At 8:39 a.m., the HHA was observed to wash the patient's genitals with the white washcloth, then place it in the bath basin. The HHA then wiped the patient's genitals with the blue washcloth, and placed it over the arm of the hoyer lift [a device used to lift immobile patients]. At 8:43 a.m., the HHA was observed to place the white washcloth in the basin and wash both of the patient's legs, then place the blue washcloth in the basin and wipe both patient's upper legs. Both washcloths were placed on the arm of the hoyer lift after use. At 8:44 a.m., the HHA was observed to turn the patient onto their left side. The HHA placed the white washcloth in the basin, wiped the patient's buttocks, and repeated with blue washcloth. Both washcloths were placed on the arm of the hoyer lift after use. At 8:53 a.m., the HHA placed the</p>	G 682			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 682	<p>Continued From page 74</p> <p>white washcloth in the basin and then used it to wash the patients lower legs and feet. After drying and dressing patient, at 9:07 a.m., the HHA was observed to use the hooyer lift to transfer the patient to a chair. The HHA failed to clean the hooyer lift, where the soiled washcloths had been before using it.</p> <p>On 1/15/2021 at 4:19 p.m., the infection control concern was discussed with the administrator. The administrator remained silent.</p> <p>5. During a home visit on 1/14/2021 for patient #3, employee C, RN [registered nurse] was observed placing a plastic bag of gloves on the kitchen table, failing to use a barrier. Employee C, RN removed a pair of gloves from the bag, donned the gloves, and placed the plastic bag back into her work bag. Employee C, RN removed the blood pressure cuff and thermometer from her bag and placed them on the table failing to place them on a barrier. After using the blood pressure cuff and thermometer they were placed back in her bag, employee C, RN failed to have cleansed or sanitized the blood pressure cuff and thermometer before placing them back into the bag. She cleansed the bell of her stethoscope and then listened to the patient's heart, lungs and bowel sounds. She removed her binder and placed it on the table, failing to use a barrier. She donned gloves, removed the patient's plan of care sheet from her binder and filled his mediplanner for the week. She removed a blank nursing note from her binder failing to remove her gloves or sanitize her hands before going into her</p>	G 682			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 682	Continued From page 75 binder. She removed her phone from her bag to call the pharmacy, failing to remove her gloves after handling the patient medication. During this visit employee C, RN, failed to wash her hands and remove her gloves before going into her bag, failed to place clean items on a barrier, failed to cleanse her supplies prior to placing them back into her bag, and failed to screen the patient for Covid-19.  During an interview on 1/15/2020 at 3:06 p.m., the administrator indicated patients are called over the phone prior to going to the home for Covid-19.	G 682			
G 684	17-12-1(m) Infection control CFR(s): 484.70(b)(1)(2)  Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include:  (1) A method for identifying infectious and communicable disease problems; and  (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. This STANDARD is not met as evidenced by: Based on record review and interview, the home health agency failed to maintain a program for	G 684			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 684	<p>Continued From page 76</p> <p>identification, prevention, control and investigation of infectious and communicable diseases specific to care and services provided in the home setting.</p> <p>The findings include:</p> <p>Record review on 1/15/2020, evidenced an undated agency policy titled "Quality Assessment and Performance Improvement" which stated, "... Indicators are measured, analyzed and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, the Agency's services and operations...."</p> <p>Clinical record review on 1/20/2021 for patient #2, with start of care 9/24/2019. and certification period 11/17/2020 to 1/15/2021, evidenced an agency document titled "Medication Profile", reviewed by the nurse on 11/4/2020. This document indicated the patient took Bactrim DS [an antibiotic] from 1/17/2020 to 1/31/2020.</p> <p>During an interview on 1/15/2021 at 3:00 p.m., the administrator indicated the agency's infection log was included in their QAPI [quality assessment and performance improvement] program.</p> <p>Review of the agency's QAPI program on 1/15/2021, failed to evidence an infection log entry for patient #2.</p> <p>During an interview on 1/15/2021 at 3:15 p.m., the administrator indicated the agency only tracked hospitalized patients in the log. The agency failed to keep a log for surveillance of infections in patients who were not hospitalized.</p>	G 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 706 G 706	Continued From page 77 Interdisciplinary assessment of the patient CFR(s): 484.75(b)(1)  Ongoing interdisciplinary assessment of the patient; This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure all skilled professional staff were involved in the patient's physical therapy plan of care and the physical therapy plan of care was signed and approved by the primary care physician, in 1 of 2 clinical records reviewed of patients receiving physical therapy, out of a total sample of 9 clinical records reviewed.(#7)  The findings include:  1. Record review on 1/19/2021, evidenced an agency policy titled, "Skilled Professional Services", dated 1/14/2018. This policy stated, "Definition: Skilled professional services include: skilled nursing services, physical therapy, speech-language, pathology services, occupational therapy, physician and medical social work services. Policy: 1. Skilled professional service providers assume the following responsibilities a. Ongoing interdisciplinary assessment of the patient. b. Development and evaluation of the plan of care in partnership with the patient, representative (if any) and caregiver(s). c. Providing services that are ordered by the physician as indicated in the plan of care...."  2. Record review evidenced an agency policy titled, "Physical Therapy", dated 1/14/2018. This policy stated, "... 2. Responsible [sic]: a. Assists the physician in evaluating in evaluating [sic] the patient's level of function. b. Participates	G 706 G 706			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 706	Continued From page 78 in the development and revision of the plan of care...."  3. Clinical record review on 1/19/2021 for patient #7, with start of care 4/1/2020 and certification period 9/28/2020 to 11/26/2020, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". This plan of care failed to evidence any reference to the patient receiving physical therapy or a physical therapy plan of care.  During an interview on 1/20/2021 at 2:10 p.m., the administrator indicated when physical therapy is ordered, the physical therapist does an evaluation and creates a plan of care. That plan of care should be approved by the physician, signed, and added as an addendum to the patient's general plan of care. The administrator indicated the agency failed to include physical therapy in the patient's plan of care and offered no further documentation.	G 706			
G 710	17-12-2(g) Provide services in the plan of care CFR(s): 484.75(b)(3)  Providing services that are ordered by the physician as indicated in the plan of care;	G 710			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 710	<p>Continued From page 79</p> <p>This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the skilled nurse failed to provide services ordered by the physician as indicated in the plan of care in 8 of 9 records reviewed receiving skilled nursing services.(#2, #3, #4, #5, #6, #7, #8, #9)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Record review on 1/19/2021, evidenced an agency policy titled "Skilled Professional Services", dated 1/14/2018. This policy stated, " ... Skilled professional service providers assume the following responsibilities ... c. Providing services that are ordered by the physician as indicated in the plan of care...."</li> <li>Observation of a home visit for patient #2 on 1/15/2021 at 1:19 p.m., employee I, LPN [licensed practical nurse] failed to perform a cardiovascular or respiratory assessment. At 1:29 p.m., employee I stated, "[employee K, home health aide] already got vitals [vital signs-temperature, pulse, respiratory rate, blood pressure] for me."</li> </ol> <p>Clinical record review on 1/20/2021 for patient #2, with start of care 9/24/2019 and certification period 11/17/2020 to 1/15/2021, evidenced an agency document titled "Skilled Nursing Note", dated 1/15/2021, signed by employee I. In this assessment, the cardiovascular and respiratory assessments were documented as "WNL" [within normal limits].</p> <p>During an interview on 1/20/2021 at 11:11 a.m., the administrator indicated a cardiovascular assessment would be done by checking the</p>	G 710			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 710	<p>Continued From page 80</p> <p>patient's pulse, and a respiratory assessment would be done by assessing the patient's respiratory rate. The administrator acknowledged the patient's pulse and respiratory rate were only assessed by the home health aide prior to the LPN's arrival, and offered nothing further.</p> <p>Clinical record review on 1/19/2021 evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician. This plan of care contained a subcategory titled "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)", which stated, "SN [skilled nurse] 2-3 x week 9 [2 to 3 times per week for 9 weeks] Vitals [vital signs-temperature, pulse, respiratory rate, and blood pressure] Q [each] visit measure wounds at least 1 time [sic] week ... Notify physician of ... change in wound status increased drainage, odor..."</p> <p>Clinical record review evidenced a group of documents titled "Skilled Nursing Note". The following skilled nursing notes, signed by employee I, failed to evidence the size, stage, shape, and measurement of the wound. These visits are dated: 11/18/2020, 11/20/2020, 11/25/2020, 11/27/2020, 12/2/2020, 12/4/2020, 12/9/2020, 12/11/2020, 12/16/2020, 12/18/2020 and 1/15/2020. A skilled nurse's note dated 11/30/2020, signed by the administrator, failed to indicate the stage of the wound.</p> <p>During an interview on 1/20/2021 at 10:47 a.m., the administrator indicated the patient's wound could not be measured.</p> <p>Clinical record review evidenced the skilled nurse's notes dated 11/30/2020, 12/23/2020, and</p>	G 710			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 710	<p>Continued From page 81</p> <p>12/28/2020, signed by the administrator, each evidenced wound measurements.</p> <p>During an interview on 1/20/2021 at 10:48 a.m., the administrator was presented with these concerns and remained silent.</p> <p>3. Clinical record review on 1/19/2021 for patient #6, with start of care 6/17/2019 and certification period 10/9/2020 to 12/7/2020, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". This document had a subcategory titled "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)" which stated, " ... 1 x week 9 [one time a week for 9 weeks] Assess VS and all body systems ... Notify physician of B/P [blood pressure] &gt;150/90 [greater than 150/90] ,&lt;100/60 [less than 100/60], pulse rate &gt;100 and &lt;60...."</p> <p>Clinical record review evidenced a group of agency documents titled "Skilled Nursing Note", dated 10/12/2020, 10/26/2020, 11/2/2020, 11/9/2020, 11/16/2020, 11/23/2020, and 11/30/2020. The assessment documented on each of these assessments failed to evidence the patient was blind. Each of the nursing notes failed to evidence a musculoskeletal [relating to muscles and bones], neurological [relating to the brain and nerves], and skin assessment.</p> <p>During an interview on 1/20/2021 at 12:00 p.m., the administrator indicated the skilled nursing notes failed to evidence an assessment of all body systems.</p> <p>Clinical record review of a skilled nursing note dated 11/2/2020 evidenced a patient blood</p>	G 710			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 710	<p>Continued From page 82</p> <p>pressure of 96/66. This note failed to evidence physician notification of the blood pressure. Review of a skilled nursing note dated 11/16/2020 evidenced a patient blood pressure of 96/89. This note failed to evidence physician notification of the blood pressure. Clinical record review of patient's record from 10/9/2020 to 12/7/2020 evidenced one narrative note, dated 10/19/2020. This narrative note failed to evidence physician notification of the patient's blood pressure.</p> <p>During an interview on 1/20/2021 at 12:05 p.m., the administrator indicated the skilled nurse should have notified the physician and documented the communication in a narrative note. No further documentation received.</p> <p>4. Clinical record review on 1/19/2021 for patient #7, with start of care 4/1/2020 and certification period 9/28/2020 to 11/26/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE". This plan of care evidenced a subcategory titled, "Other Pertinent Diagnoses" which stated, "Unspecified dementia without behavioral dis [disturbance] [a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems] ... Blindness, both eyes...."</p> <p>Review of the plan of care evidenced a subcategory titled, "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)", which stated, "SN [skilled nurse] 2-3 x week 9 [2 to 3 times per week for 9 weeks]. Assess VS and all body systems...."</p> <p>Clinical record review evidenced a group of agency documents titled "Skilled Nursing Note".</p>	G 710			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 710	<p>Continued From page 83</p> <p>The assessments dated 9/28/2020, 9/30/2020, 10/3/2020, 10/7/2020, 10/10/2020, 10/12/2020, 10/14/2020, 10/16/2020, and 11/18/2020, failed to evidence the patient was blind. The assessments with the following dates failed to evidence a musculoskeletal [relating to muscles and bones], neurological [relating to the brain and nerves], and skin assessment: 9/28/2020, 9/30/2020, 10/3/2020, 10/7/2020, 10/10/2020, 10/12/2020, 10/14/2020, 10/16/2020, 10/19/2020, 10/21/2020, 10/24/2020, 10/26/2020, 10/28/2020, 10/31/2020, 11/2/2020, 11/4/2020, 11/6/2020, 11/9/2020, 11/11/2020, 11/13/2020, 11/16/2020, 11/18/2020, 11/21/2020, 11/23/2020, and 11/25/2020.</p> <p>During an interview on 1/20/2021 at 2:30 p.m., the administrator indicated the skilled nursing notes failed to evidence an assessment of all body systems.</p> <p>5. Clinical record review on 1/19/2021 for patient #4, start of care 10/4/2017, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE, for certification period 7/20/2020 to 9/17/2020, and signed by employee C, RN [Registered Nurse] and physician I, MD [medical doctor], which had a subsection titled "Orders for Discipline and Treatments" that stated, VA [veteran administration] fee based 1-2 x week 9. [1-2 times a week for 9 weeks] Assess VS [vital signs] and all body systems ...."</p>	G 710			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 710	Continued From page 84  Clinical record review on 1/19/2020, evidenced agency documents titled, "Skilled Visit Note" signed by employee I, LPN and dated 3/26/20, 4/22/2020, 4/24/2020, 6/30/2020 and 7/3/2020. These documents had a subsection titled "ASSESSMENT-homebound status" which failed to evidence any assessment documentation.  Clinical record review on 1/19/2020, evidenced agency documents titled, "Skilled Visit Note" signed by employee C, RN and dated 5/28/2020, 6/4/2020, 6/23/2020 and 6/25/2020. These documents had subsections titled "LEVEL OF PAIN, MUSCULOSKELETAL [having to do with the muscles and bones], and NEUROLOGICAL" which failed to evidence any assessment documentation.  Clinical record review on 1/19/2020, for patient #4, evidenced agency documents titled, "Skilled Visit Note" signed by employee C, RN and dated 1/7/2020, 1/9/2020, 1/14/2020, 1/16/2020, 1/28/2020 1/23/2020, 2/6/2020, 2/7/2020, 2/20/2020,2/25/2020, 3/5/2020 2 1/21/2020, 3/5/2020, 3/10/2020, 3/12/2020, 3/17/2020, 3/19/2020, 3/24/2020, 3/31/2020, 4/2/2020, 4/7/2020, 4/9/2020, 4/14/2020, 4/16/2020, 4/28/2020, 4/30/2020, 5/5/2020, 5/7/2020, 5/19/2020, 5/20/2020, 5/21/2020, 5/26/2020, 6/2/2020, 6/9/2020, 6/11/2020, 6/16/2020, 6/18/2020, 6/30/2020, 7/14/2020, 7/16/2020, 7/21/2020, and 7/23/2020. These documents had subsections titled "MUSCULOSKELETAL and NEUROLOGICAL" which failed to evidence any assessment documentation.  Clinical record review on 1/19/2020 for patient #4, evidenced an agency document titled	G 710			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 710	<p>Continued From page 85</p> <p>"Comprehensive Adult Assessment" signed by employee C and dated 5/15/2020. This document had subsections titled "IMMUNIZATION/SCREENING TESTS, and PATIENT HISTORY AND DIAGNOSIS," which failed to evidence any assessment documentation.</p> <p>During an interview on 1/20/2020 at 3:19 p.m., the administrator indicated she was unsure why parts of the assessment were not filled out.</p> <p>6. Clinical record review on 1/19/2021 for patient #9, start of care 6/3/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE, for certification period 10/1/2020 to 11/29/2020, and signed by the clinical manager. This document had a subsection titled "Orders for Discipline and Treatments" which stated, SN [skilled nursing]1-2 x week 9. [1-2 times a week for 9 weeks] Assess VS and all body systems ...."</p> <p>Clinical record review on 1/19/2020 for patient #9, evidenced an agency document titled "Comprehensive Adult Assessment-Resumption of Care" signed by employee I, LPN and dated 8/18/2020. This document had subsections titled "SENSORY STATUS, WOUND CARE/INTERVENTIONS, and FALL RISK ASSESSMENT" which failed to evidence any assessment documentation.</p> <p>Clinical record review on 1/19/2021 for patient #9, evidenced an agency document titled "Recertification/Follow-Up," signed by the clinical manager, and dated 9/30/2020. This document had a subsection titled "Musculoskeletal, "which</p>	G 710			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 710	<p>Continued From page 86</p> <p>failed to evidence any documentation. There was a subsection titled "Wound Location," which failed to evidence any documentation. There was a subsection titled "Wound Care," which stated "N/A [not applicable]" This document failed to evidence the wound care being provided to patient #9.</p> <p>Clinical record review on 1/19/2020, evidenced agency documents titled, "Skilled Visit Note" signed by employee C, RN, and dated 10/5/2020, 10/7/2020, 10/12/2020, 10/14/2020, 10/19/2020, 10/21/2020, 10/23/2020, 10/26/2020, 10/28/2020, 10/30/2020, 11/2/2020, 11/4/2020, 11/6/2020, 11/11/2020, 11/16/2020, 11/18/2020, 11/19/2020, 11/20/2020 11/23/2020, and 11/27/2020. These documents had subsections titled "MUSCULOSKELETAL and NEUROLOGICAL" which failed to evidence any assessment documentation.</p> <p>Clinical record review on 1/19/2020, evidenced agency documents titled, "Skilled Visit Note" signed by employee C, RN and dated 10/5/2020, 10/7/2020, 10/9/2020, 10/12/2020, 10/14/2020, 10/19/2020, 10/21/2020, 10/23/2020, 10/26/2020, 10/28/2020, 10/30/2020, and 11/20/2020. These documents had subsections titled "LEVEL OF PAIN" which failed to evidence any assessment documentation.</p> <p>Clinical record review on 1/19/2020, evidenced agency documents titled, "Skilled Visit Note" signed by employee C, RN and dated 10/9/2020, 10/26/2020, and 10/28/2020. These documents had subsections titled "ASSESSMENT-homebound status" which failed to evidence any assessment documentation.</p>	G 710			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 710	<p>Continued From page 87</p> <p>During an interview on 1/19/2020 at 3:50 p.m., the clinical manager indicated all the sections of the nursing assessment should be filled in. She indicated she was not sure why those sections were missed.</p> <p>7. Clinical record review on 1/19/2021 for patient #5, start of care 4/11/2017, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE", for certification period 11/27/2019 to 1/25/2020, and signed by the clinical manager. This document had a subsection titled "Orders for Discipline and Treatments" which stated, SN 1-2 x week 9. Assess VS [vital signs] and all body systems ...."</p> <p>Clinical record review on 1/19/2021 for patient #5, start of care 4/11/2017, evidenced agency documents titled, "Skilled Visit Note" which were dated 12/20/2019, 12/23/2019, 12/27/2019, 1/3/2020, and 1/10/2020, and signed by the clinical manager. These documents had subsections titled "ASSESSMENT homebound status, NEUROLOGICAL and MUSCULOSKELETAL," which failed to evidence any assessment documentation.</p> <p>Clinical record review on 1/19/2021 for patient #5, start of care 4/11/2017, evidenced agency documents titled, "Skilled Visit Notes" which were dated 1/28/2020, 2/1/2020, 2/4/2020, 2/8/2020, 2/11/2020, 2/13/2020, 2/18/2020, 2/21/2020, 2/25/2020, 3/3/2020, 3/7/2020, 3/10/2020, 3/14/2020, 3/19/2020, 3/22/2020, 3/24/2020, 3/27/2020, 3/31/2020, 4/4/2020, 4/7/2020, 4/10/2020, 4/14/2020, 4/18/2020, 4/22/2020, 4/25/2020 and signed by employee I, LPN. These documents had subsections titled "ASSESSMENT homebound status,</p>	G 710			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 710	<p>Continued From page 88</p> <p><b>NEUROLOGICAL and MUSCULOSKELETAL"</b> which failed to evidence any assessment documentation.</p> <p>During an interview on 1/20/21 at 11:40 a.m., the administrator asked to see the documents. She indicated she was not sure why the areas were not filled out on the nursing notes.</p> <p>Clinical record review on 1/19/2021 for patient #5, start of care 4/11/2017, evidenced an unsigned agency document titled "Adult Re-Assessment," dated 1/23/2017. This document had subsections titled "MEASURABLE OUTCOMES AND GOALS" which failed to evidence any documentation.</p> <p>During an interview on 1/20/2021 at 11:25 a.m., the clinical manger indicated she forgot to sign the document and must have missed the section that was not complete.</p> <p>8. Clinical record review on 1/19/2021 for patient #8, start of care 8/21/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE", for certification period 10/20/2020 to 12/18/2020, and signed by the clinical manager. This document had a subsection titled "Orders for Discipline and Treatments" which stated, SN 1-2 x week 9. [1-2 times a week for 9 weeks] Assess VS and all body systems ...."</p> <p>Clinical record review on 1/19/2021, evidenced agency documents titled, "Recertification / Follow-Up" signed by the clinical manager and dated 12/11/2020 and 10/16/2020. These documents had subsections titled "MUSCULOSKELETAL and NEUROLOGICAL" which failed to evidence any assessment</p>	G 710			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 710	<p>Continued From page 89 documentation.</p> <p>Clinical record review on 1/19/2021, evidenced agency documents titled, "Skilled Nursing Note" signed by employee I, LPN and dated 10/2/2020 and 12/4/2020. These documents had subsections titled "MUSCULOSKELETAL, NEUROLOGICAL, and ASSESSMENT homebound status" which failed to evidence any assessment documentation.</p> <p>Clinical record review on 1/19/2021, evidenced agency documents titled, "Skilled Nursing Note" signed by employee I, LPN and dated 9/18/2020, 9/25/2020, 10/9/2020, 10/16/2020, 10/24/2020, 10/30/2020, 11/7/2020, 11/13/2020, 11/19/2020, 11/27/2020, 12/11/2020, 12/11/2020, 12/17/2020, 12/27/2020 and 12/31/2020. These documents had subsections titled "MUSCULOSKELETAL, NEUROLOGICAL, and ASSESSMENT homebound status" which failed to evidence any assessment documentation.</p> <p>During an interview on 1/21/2021 at 1:50 p.m., the clinical manager indicated she was unsure why all the areas of the assessment were not documented, but everything should be completely filled out.</p> <p>9. Clinical record review on 1/19/2021 for patient #3, start of care 12/2/2019, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE", for certification period 9/27/2020 to 11/25/2020, and signed by employee C, RN. This document had a subsection titled "Orders for Discipline and Treatments" which stated, VA fee based 1-2 x week 9. [1-2 times a week for 9 weeks] Assess VS and all body systems ...."</p>	G 710			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 710	Continued From page 90  Clinical record review on 1/19/2021 for patient #3, evidenced an agency document titled, "Skilled Nursing Note" signed by employee C, RN and dated 10/14/2020. This document had a subsection titled Musculoskeletal, Neurological and ASSESSMENT homebound status" which failed to evidence any assessment documentation.  Clinical record review on 1/19/2021 for patient #3, evidenced agency documents titled, "Skilled Nursing Note" signed by employee C, RN and dated 10/2/2020, 10/6/2020, 10/9/2020, 10/20/2020, 10/23/2020, 10/27/2020 10/30/2020, 11/3/2020, 11/6/2020, 11/10/2020, 11/14/2020, 11/17/2020, 11/20/2020, 11/24/2020, 11/27/2020, and 12/1/2020. These documents had subsections titled "Musculoskeletal" and "Neurological" which failed to evidence any assessment documentation.  During an interview on 1/21/2021 at 10:45 a.m., the clinical manager indicated those areas must have been missed when documenting.	G 710			
G 716	17-14-1(a)(1)(H)-RN Preparing clinical notes CFR(s): 484.75(b)(6)  Preparing clinical notes; This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the skilled nurse prepared the clinical notes accurately and completely in 7 of 9 clinical records reviewed. (#2, #3, #4, #5, #6, #8, #9)	G 716			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 716	<p>Continued From page 91</p> <p>The findings include:</p> <p>1. Record review on 1/20/2021 evidenced an agency policy titled, "Skilled Nursing Note / Care Plan", dated 1/14/2018. This policy stated, "1. Purpose: To establish a mean of documenting home visit, serviced [sic] provided, patient's problems, interventions, and goals. To provide a method to evaluate the outcome of the nursing care provided ... 3. Procedure: a. The skilled nursing note is completed by the nurse to document each home visit and includes: i. Subjective ii. Objective iii. Assessment iv. Intervention v. Outcome vi. Plan ...."</p> <p>2. Clinical record review on 1/20/2021 for patient #2, start of care 09/24/2019, evidenced an agency document titled "Skilled Nursing Note", dated 1/15/2021, signed by employee I. In this assessment, the cardiovascular and respiratory assessments were documented as "WNL" [within normal limits].</p> <p>Observation of a home visit for patient #2 on 1/15/2021 at 1:19 p.m., employee I, LPN [licensed practical nurse] failed to perform a cardiovascular or respiratory assessment. At 1:29 p.m., employee I stated, "[employee K, home health aide] already got vitals [vital signs-temperature, pulse, respiratory rate, blood pressure] for me."</p> <p>During an interview on 1/20/2021 at 11:11 a.m., the administrator indicated a cardiovascular assessment would be done by checking the patient's pulse, and a respiratory assessment would be done by assessing the patient's respiratory rate. The administrator acknowledged</p>	G 716			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 716	<p>Continued From page 92</p> <p>the patient's pulse and respiratory rate were only assessed by the home health aide prior to the LPN's arrival, and offered nothing further.</p> <p>3. Clinical record review on 01/19/2021 for patient #6, start of care 06/17/2019, certification period 10/09/2020 - 12/07/2020, evidenced an agency policy titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". This plan of care had a subcategory titled, "Other Pertinent Diagnoses", which stated, " ... Blindness, both eyes...."</p> <p>Clinical record review evidenced a group of agency documents titled "Skilled Nursing Note", dated 10/12/2020, 10/26/2020, 11/2/2020, 11/9/2020, 11/16/2020, 11/23/2020, and 11/30/2020. The assessment documented on each of these assessments failed to evidence the patient was blind. Each of the nursing notes failed to evidence a musculoskeletal [relating to muscles and bones], neurological [relating to the brain and nerves], and skin assessment.</p> <p>During an interview on 1/20/2021 at 12:00 p.m., the administrator indicated the skilled nurse failed to document a complete assessment.</p> <p>4. Clinical record review on 1/19/2021 for patient #3, evidenced an agency document titled, "Skilled Nursing Note" signed by employee C, RN and dated 10/14/2020. This document had subsections titled "Musculoskeletal, Neurological and ASSESSMENT homebound-status" which failed to evidence any documentation.</p>	G 716			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 716	<p>Continued From page 93</p> <p>Clinical record review on 1/19/2021 for patient #3, evidenced agency documents titled, "Skilled Nursing Note" signed by employee C, RN and dated 10/2/2020, 10/6/2020, 10/9/2020, 10/20/2020, 10/23/2020, 10/27/2020 10/30/2020, 11/3/2020, 11/6/2020, 11/10/2020, 11/14/2020, 11/17/2020, 11/20/2020, 11/24/2020, 11/27/2020, and 12/1/2020. These documents had subsections titled "Musculoskeletal and Neurological," which failed to evidence any documentation.</p> <p>During an interview on 1/21/2021 at 10:45 a.m., the clinical manager indicated those areas must have been missed when documenting.</p> <p>5. Clinical record review on 1/19/2021 for patient #4, evidenced agency documents titled "Skilled Visit Note" signed by employee I, LPN and dated 3/26/20, 4/22/2020, 4/24/2020, 6/30/2020, and 7/3/2020. These documents had a subsection titled "ASSESSMENT," which failed to evidence any documentation.</p> <p>Clinical record review on 1/19/2021 for patient #4, evidenced agency documents titled, "Skilled Visit Note" signed by employee C, RN and dated 5/28/2020, 6/4/2020, 6/23/2020, and 6/25/2020, these documents had subsections titled "LEVEL OF PAIN, Musculoskeletal [having to do with the muscles and bones], and Neurological [having to do with the brain]," which failed to evidence any documentation.</p> <p>Clinical record review on 1/19/2021 for patient #4, evidenced agency documents titled, "Skilled Visit Note" signed by employee C, RN and dated 1/7/2020, 1/9/2020, 1/14/2020, 1/16/2020,</p>	G 716			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 716	<p>Continued From page 94</p> <p>1/23/2020, 1/28/2020, 2/6/2020, 2/7/2020, 2/20/2020, 2/25/2020, 3/5/2020, 1/21/2020, 3/5/2020, 3/10/2020, 3/12/2020, 3/17/2020, 3/19/2020, 3/24/2020, 3/31/2020, 4/2/2020, 4/7/2020, 4/9/2020, 4/14/2020, 4/16/2020, 4/28/2020, 4/30/2020, 5/5/2020, 5/7/2020, 5/19/2020, 5/20/2020, 5/21/2020, 5/26/2020, 6/2/2020, 6/9/2020, 6/11/2020, 6/16/2020, 6/18/2020, 6/30/2020, 7/14/2020, 7/16/2020, 7/21/2020, and 7/23/2020. These documents had subsections titled "Musculoskeletal and Neurological," which failed to evidence any documentation.</p> <p>6. Clinical record review on 1/19/2021 for patient #5, start of care 4/11/2017, evidenced agency documents titled, "Skilled Visit Note" dated 12/20/2019, 12/23/2019, 12/27/2019, 1/3/2020, and 1/10/2020, and signed by the clinical manager. These documents had subsections titled "ASSESSMENT-homebound status, Neurological and Musculoskeletal," which failed to evidence any documentation.</p> <p>Clinical record review on 1/19/2021 for patient #5, evidenced agency documents titled, "Skilled Visit Notes," which were dated 1/28/2020, 2/1/2020, 2/4/2020, 2/8/2020, 2/11/2020, 2/13/2020, 2/18/2020, 2/21/2020, 2/25/2020, 3/3/2020, 3/7/2020, 3/10/2020, 3/14/2020, 3/19/2020, 3/22/2020, 3/24/2020, 3/27/2020, 3/31/2020, 4/4/2020, 4/7/2020, 4/10/2020, 4/14/2020, 4/18/2020, 4/22/2020, and 4/25/2020 and signed by employee I, LPN. These documents had subsections titled "ASSESSMENT-homebound status, Neurological and Musculoskeletal," which failed to evidence any documentation.</p> <p>Clinical record review on 1/19/2021 for patient #5,</p>	G 716			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 716	<p>Continued From page 95</p> <p>evidenced an unsigned agency document titled "Adult Re-Assessment," dated 1/23/2020. This document had a subsection titled "MEASURABLE OUTCOMES AND GOALS," which failed to evidence any documentation.</p> <p>7. Clinical record review on 1/19/2021 for patient #8, start of care 08/21/2020, evidenced agency documents titled, "Recertification / Follow-Up" signed by the clinical manager and dated 12/11/2020 and 10/16/2020. These documents had subsections titled "Musculoskeletal and Neurological," which failed to evidence any documentation.</p> <p>Clinical record review on 1/19/2021 for patient #8, evidenced agency documents titled, "Skilled Nursing Note" signed by employee I, LPN and dated 10/2/2020 and 12/4/2020. These documents had subsections titled "Musculoskeletal, Neurological, and ASSESSMENT-homebound status," which failed to evidence any documentation.</p> <p>8. Clinical record review on 1/19/2021 for patient #9, evidenced agency documents titled, "Skilled Visit Note," signed by employee C, RN and dated 10/5/2020, 10/7/2020, 10/12/2020, 10/14/2020, 10/19/2020, 10/21/2020, 10/23/2020, 10/26/2020, 10/28/2020, 10/30/2020, 11/2/2020, 11/4/2020, 11/6/2020, 11/11/2020, 11/16/2020, 11/18/2020, 11/19/2020, 11/20/2020 11/23/2020, and 11/27/2020. These documents had subsections titled "Musculoskeletal and Neurological," which failed to evidence any documentation.</p> <p>Clinical record review on 1/19/2021 for patient #9, evidenced agency documents titled, "Skilled Visit Note" signed by employee C, RN and dated</p>	G 716			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 716	Continued From page 96 10/5/2020, 10/7/2020, 10/9/2020, 10/12/2020, 10/14/2020, 10/19/2020, 10/21/2020, 10/23/2020, 10/26/2020, 10/28/2020, 10/30/2020, and 11/20/2020. These documents had a subsection titled "LEVEL OF PAIN," which failed to evidence any documentation.  Clinical record review on 1/19/2021 for patient #9, evidenced agency documents titled, "Skilled Visit Note" signed by employee C, RN and dated 10/9/2020, 10/26/2020, and 10/28/2020. These documents had subsections titled "ASSESSMENT- homebound status," which failed to evidence any documentation.  During an interview on 1/19/2020 at 3:50 p.m., the clinical manager indicated that all the sections of the nursing assessment should be filled in. She indicated she was not sure why those sections were missed.	G 716			
G 798	17-14-1(a)(1)(E) 17-14-1(a)(2)(B) Home health aide assignments and duties CFR(s): 484.80(g)(1)  Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). This STANDARD is not met as evidenced by:	G 798			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 798	<p>Continued From page 97</p> <p>Based on record review and interview, the agency failed to ensure the registered nurse provided a complete and appropriate care plan for the home health aide [HHA] in 1 of 1 home visits conducted with a home health aide. (#1)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Record review on 1/19/2021, evidenced an agency document titled "Registered Nurse", dated 1/14/2018. This document stated, " ... The Registered Nurse or Therapist conducts a Home Health Aide supervisory visit no less frequent than every two (2) weeks ... a. The Home Health Aide is provided with a written care plan that outlines task to be performed. b. The care plan is reviewed and updated at least every sixty (60) days or more frequently if indicated...."</li> <li>Clinical record review on 1/12/2021 for patient #1, with start of care 9/14/2018 and certification period 11/2/2020 to 12/31/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician. This plan of care had a subcategory titled "Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" which stated, "Medicaid HHA (home health aide) 3-5 x week [3 to 5 times per week] 9 8 hours a daym [sic]. To facilitate caregivers employment and to prevent nursing home placement. Personal care and assistance with ADL [activities of daily living]. Personal care to include: Bed bath, oral hygiene, dress, shampoo, hair care, skin care, linen change, vital signs, tidy room, record BM [bowel movement], meal preparation as requested, assist to chair, record fluid intake and turn/position...."</li> </ol>	G 798			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 798	Continued From page 98  Clinical record review evidenced an agency document titled "Home Health Aide Care Plan / Assignment", reviewed and signed by the administrator on 12/30/2020. This aide care plan failed to indicate the following tasks: oral hygiene, dress, shampoo, hair care, linen change, vital signs, tidy room, record BM, prepare food as requested, record oral intake amount, and turn/position.  During an interview on 1/20/2021 at 10:30 a.m., the administrator indicated she failed to ensure the HHA care plan was complete.	G 798			
G 804	17-13-2(a) Aides are members of interdisciplinary team CFR(s): 484.80(g)(4)  Home health aides must be members of the interdisciplinary team, must report changes in the patient's condition to a registered nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the home health aide reported changes in the patient's condition to the supervising nurse in 1 of 3 clinical records reviewed with home visits conducted, out of a total sample of 9 clinical records reviewed. (#2)  The findings include:  1. Record review on 1/19/2021, evidenced an agency policy titled "Home Health Aide Services", dated 1/14/2018. This policy stated, " ... A home	G 804			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 804	<p>Continued From page 99</p> <p>health aide competency training program must address ... Observation, reporting, and documentation of patient status and the care or service furnished ... Home Health Aides are assigned to a specific patient ... with written patient care instructions for a home health aide prepared by that Registered Nurse or other appropriate skilled professional ... Home health aides must be members of the interdisciplinary team, must report changes in the patient's condition to a registered nurse or other appropriate skilled professional...."</p> <p>2. Record review evidenced an agency policy titled "Registered Nurse", dated 1/14/2018. This policy stated, "The Home Health Aide is required to notify the nurse of any changes in the patient's condition ... Documentation of the nurse contact is required on the HHA [home health aide] Clinical Note...."</p> <p>3. Clinical record review on 1/19/2021 for patient #2, with start of care 9/24/2019 and certification period 11/17/2020 to 1/15/2021, evidenced an agency document titled "Home Health Aide Care Plan / Assignment", reviewed on 11/4/2020 ,by the administrator. This care plan stated, " ... Notify Nurse T &gt; 99 [temperature greater than 99], P &gt; 100 &lt; 60 [pulse rate greater than 100 or less than 60], R &gt; 24 &lt;14 [respiratory rate greater than 24 or less than 14], B/P &gt; 160/90 &lt; 90/60 [blood pressure greater than 160/90 or less than 90/60]."</p> <p>Clinical record review evidenced a group of agency documents titled "Home Health Aide Documentation Sheet". A note dated 11/25/2020, indicated the patient's blood pressure was 88/60. This note failed to evidence the HHA notified the</p>	G 804			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 804	Continued From page 100 supervising nurse. A note dated 12/22/2020, indicated the patient's blood pressure was 88/63. This note failed to evidence the HHA notified the supervising nurse. A note dated 1/1/2021, indicated the patient's pulse rate was 104. This note failed to evidence the HHA notified the supervising nurse.  During an interview on 1/20/2021 at 11:09 a.m., the administrator indicated the HHA should have notified the supervising nurse on each occurrence and documented this communication in the HHA visit notes.	G 804			
G 818	HH aide supervision elements CFR(s): 484.80(h)(4)(i-vi)  Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the supervising registered nurse ensured home health aide care was	G 818			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 818	<p>Continued From page 101</p> <p>complete, safe, effective, and followed the patient's plan of care in 1 of 3 clinical records reviewed with a home visit conducted, out of a total sample of 9 clinical records reviewed. (#2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Record review on 1/19/2021, evidenced an agency policy titled "Home Health Aide Services", dated 1/14/2018. This policy stated, " ... All home health aide services provided by individuals who have completed successfully a Home health aide training ... while providing services ... under the direct supervision of a registered nurse, or a licensed practical nurse who is under the supervision of a registered nurse...."</li> <li>Clinical record review on 1/19/2021 for patient #2, with start of care 9/24/2019, and certification period 11/17/2020 to 1/15/2021, evidenced a group of agency documents titled "Home Health Aide Documentation Sheet" dated from 11/16/2020 to 1/1/2021, signed by employee K. These HHA [home health aide] documentation sheets had a section titled "Significant details". This section evidenced the following narratives: "[undated] Wound has gotten small area below is gone 11-24 No change 11-25 wound is still looking good 11-26 wound &amp; area below are ok but area above is reddening.", "[undated] Wound is looking ok 12-1 progressing fine 12-2 skin is reddish on left side of hip 12-3 very little change 12-4 No change but inilail [sic] wound still progressing fine.", "[undated] Wounds is [sic] healing fine 12-8 No change 12-9 wound is looking good no significant change 12-10 no change 12-11 looking good. "[undated] initial worn [sic] sm in size No drainage dry also sm reddish area circle below worm [sic], 12-15-20 No </li></ol>	G 818			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G 818	Continued From page 102 change other than reddish circle is cleared 12-16-20 same 12-17-20 initial worm [sic] look good 12-18-20 same", "[undated] Wound is healing good red area below wound 12-22-20 wound is sm but moist & red in color 12-23- no change 12-24 sm in size wound but still moist area below still red 12-25 no change", "[undated] Wound is progressing fine area below red specks 12-29 No change 12-30 No change 12-31 hasn't change area below wound 1-1-21 wound is good area below wound no change."  During an interview on 1/20/2021 at 11:09 a.m., the administrator indicated the HHA was documenting wound assessment. The administrator identified herself as the supervising nurse. When queried if it was part of the HHA's duties to assess wounds, the administrator remained silent.	G 818			
G1014	17-14-1(n) Interventions and patient response CFR(s): 484.110(a)(2)  All interventions, including medication administration, treatments, and services, and responses to those interventions; This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the patient's clinical records evidenced all interventions, treatments, services, and responses to those interventions in 3 of 3 clinical records reviewed of patients receiving wound care, out of a total sample of 9 clinical records reviewed. ( #2, #7, #9)  The findings include:	G1014			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G1014	<p>Continued From page 103</p> <p>1. Record review on 1/19/2021, evidenced an undated agency policy titled, "Clinical Records". This policy stated, " ... The clinical record includes: ... b. All interventions, including medication administration, treatments and services, and responses to those interventions...."</p> <p>During an interview on 1/20/2021 at 10:50 a.m., the administrator indicated the patient does not feel pain below the waist. When queried if the patient could evidence any other responses to wound care, the administrator remained silent.</p> <p>2. Clinical record review on 1/20/2021 for patient #2 with start of care 9/24/2019 and certification period 11/17/2020 to 1/15/2021, evidenced a group of documents titled "Skilled Nursing Note". These notes were dated 11/18/2020, 11/20/2020, 11/25/2020, 11/27/2020, 11/30/2020, 12/2/2020, 12/4/2020, 12/9/2020, 12/11/2020, 12/14/2020, 12/16/2020, 12/18/2020 and 1/15/2020, and signed by employee I, LPN [licensed practical nurse]. Each of these notes evidenced wound care was performed. Each of these notes failed to evidence the patient's response to the care provided.</p> <p>3. Clinical record review on 1/19/2021 for patient #7 with start of care 4/1/2020 and certification period 9/28/2020 to 11/26/2020 evidenced a group of agency documents titled "Skilled Nursing Note", dated 9/28/2020, 9/30/2020, 10/3/2020, 10/7/2020, 10/10/2020, 10/12/2020, 10/14/2020, 10/16/2020, 10/19/2020, 10/21/2020, 10/24/2020, 10/26/2020, 10/28/2020, 10/31/2020, 11/2/2020, 11/4/2020, 11/6/2020, 11/9/2020, 11/11/2020, 11/13/2020, 11/16/2020, 11/18/2020, 11/21/2020, 11/23/2020 and 11/25/2020. Each of these notes evidenced wound care was performed. Each of</p>	G1014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G1014	Continued From page 104 these notes failed to evidence the patient's response to the care provided.  When informed of these concerns on 1/20/2021 at 2:07 p.m., the administrator remained silent.  4. Clinical record review for patient #9, start of care 6/3/2020, evidenced agency documents titled "Skilled Nursing note" which evidenced patient #9 received wound care on 10/5/2020, 10/7/2020, 10/9/2020, 10/12/2020, 10/14/2020, 10/19/2020, 10/20/2020, 10/21/2020, 10/23/2020, 10/26/2020, 10/28/2020 10/30/2020, 11/2/2020 11/4/2020, 11/6/2020, 11/11/2020, 11/13/2020, 11/16/2020 11/17/2020, 11/23/2020 and 11/27/2020. These documents failed to evidence patient #9's response to the wound care.  During an interview on 1/21/2021 at 10:51 a.m., the clinical manager indicated the patient had complained of pain in the leg, but not from wound care.	G1014			
G1024	Authentication CFR(s): 484.110(b)  Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. This STANDARD is not met as evidenced by:	G1024			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G1024	<p>Continued From page 105</p> <p>Based on record review and interview, the home health agency failed to ensure all clinical record entries are legible, clear, complete, and appropriately authenticated in 7 out of 9 patient records reviewed. (#2, #4, #5, #6, #7, #8, #9)</p> <p>1. Record review on 1/19/2021, evidenced an undated agency policy titled "Medical Records," which stated, "1. Purpose: To provide accurate and current health care information regarding patients of the Home Health Agency ... c. All entries shall be signed with date, full first and last name and title...."</p> <p>2. Record review on 1/19/2021, evidenced an undated agency policy titled "Skilled Nursing Note/ Care Plan," which stated, "b. the skilled nursing note must include the time of the home visit, signed by the nurse and patient and dated ...."</p> <p>3. Clinical record review on 1/19/2021 for patient #4, start of care 10/4/2017, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 7/20/2020 to 9/17/2020, and signed by employee C, RN [Registered Nurse] and physician I, MD [medical doctor], which had a subsection titled "Orders for Discipline and Treatments" which stated, VA [veteran administration] fee based 1-2 x week 9. [1-2 times a week for 9 weeks] Assess VS [vital signs] and all body systems ...."</p> <p>Clinical record review on 1/19/2021 for patient #4, start of care 10/4/2017, evidenced an agency document titled "Narrative Note." This document failed to evidence the signature and credentials of the writer and the date.</p>	G1024			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G1024	<p>Continued From page 106</p> <p>Clinical record review on 1/19/2021 for patient #4, evidenced agency documents titled "Narrative Note" dated 5/19/2020 and 7/14/2020. These documents failed to evidence the writer's signature and credentials.</p> <p>Clinical record review on 1/19/2021 for patient #4, evidenced agency documents titled "Skilled Visit Note," signed by employee I, LPN [Licensed Practical Nurse] and dated 2/26/2020, 3/26/2020, 4/22/2020, 4/24/2020, 6/30/2020, 7/3/2020, 7/7/2020, and 7/10/2020. These documents failed to evidence employee I's credentials.</p> <p>4. Clinical record review on 1/19/2021 for patient #9, evidenced an agency document titled "Comprehensive Adult Assessment-Resumption of Care," signed by employee I, LPN and dated 8/18/2020. This document failed to evidence employee I's credentials.</p> <p>5. Clinical record review on 1/19/2021 for patient #5, evidenced agency documents titled, "Skilled Visit Notes" which were dated 1/28/2020, 2/1/2020, 2/4/2020, 2/8/2020, 2/11/2020, 2/13/2020, 2/18/2020, 2/21/2020, 2/25/2020, 3/3/2020, 3/7/2020, 3/10/2020, 3/14/2020, 3/19/2020, 3/22/2020, 3/24/2020, 3/27/2020, 3/31/2020, 4/4/2020, 4/7/2020, 4/10/2020, 4/14/2020, 4/18/2020, 4/22/2020, and 4/25/2020 and signed by employee I, LPN. These documents failed to evidence employee I's credentials.</p> <p>During an interview on 1/20/21 at 11:40 a.m., the administrator asked to see the documents without out the employee credentials. After reviewing the</p>	G1024			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G1024	<p>Continued From page 107</p> <p>documented she indicated the credentials were not on the documents, but they should be.</p> <p>Clinical record review on 1/19/2021 for patient #5, evidenced an unsigned agency document titled "Adult Re-Assessment," dated 1/23/2020.</p> <p>Clinical record review on 1/19/2021 for patient #5, evidenced an unsigned agency document titled "Adult Re-Assessment," dated 1/23/2020. This document failed to include the signature and credentials of the writer.</p> <p>During an interview on 1/20/2021 at 11:25 a.m., the clinical manager indicated she forgot to sign the document.</p> <p>6. Clinical record review on 1/19/2021 for patient #8, start of care 8/21/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 10/20/2020 to 12/18/2020, signed by the clinical manager. This document failed to be dated by the clinical manager.</p> <p>Clinical record review on 1/19/2021 for patient #8, start of care 8/21/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 10/20/2020 to 12/18/2020, signed by the clinical manager. This document failed to evidence the date the document was signed by the clinical manager.</p> <p>Clinical record review on 1/19/2021 for patient #8, evidenced agency documents titled, "Skilled Nursing Note" signed by employee I, LPN and dated 9/18/2020, 9/25/2020, 10/9/2020, 10/16/2020, 10/24/2020, 10/30/2020, 11/7/2020,</p>	G1024			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G1024	<p>Continued From page 108</p> <p>11/13/2020, 11/19/2020, 11/27/2020, 12/11/2020, 12/11/2020, 12/17/2020, 12/27/2020, and 12/31/2020. These documents failed to evidence employee I's credentials.</p> <p>During an interview on 1/21/2021 at 1:50 p.m., the clinical manager reviewed the documents and indicated they do not have credentials noted on them.</p> <p>7. Clinical record review on 1/19/2021 for patient #2, with start of care 9/24/2020, and certification period 11/17/2020 to 1/15/2021, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician. This plan of care contained a subcategory titled "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)", which stated, "HHA [home health aide] 3-5 x week 9 [3 to 5 times a week for 9 weeks], 2-3 hours a visit [sic] assist with personal care, colostomy, urinary incontinence and bed mobility...."</p> <p>Clinical record review evidenced an agency document titled "Case Conference" dated 12/21/2020, signed by the administrator, employee C, and employee I. This document stated, "Patient and mother decline physical therapy and home health aide services." This document failed to be authentic as evidenced below in interview.</p> <p>During an interview on 1/20/2021 at 10:47 a.m., the administrator indicated the patient was</p>	G1024			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G1024	<p>Continued From page 109</p> <p>receiving HHA services. When queried, the administrator asked to view the surveyor's copy of the case conference note, and crossed out "Patient and mother decline physical therapy and home health aide services". The administrator stated, "That's not correct".</p> <p>Clinical record review evidenced a group of documents titled "Skilled Nursing Note". The notes from the following dates, signed by employee I, failed to evidence the title of the writer: 11/18/2020, 11/20/2020, 11/25/2020, 11/27/2020, 12/2/2020, 12/4/2020, 12/9/2020, 12/11/2020, 12/16/2020, 12/18/2020 and 1/15/2020.</p> <p>During an interview on 1/20/2021 at 11:10 a.m., the administrator indicated the agency failed to ensure writers' signatures included their title.</p> <p>8. Clinical record review on 1/19/2021 for patient #6, with start of care 6/17/2019 and certification period 10/9/2020 to 12/7/2020, evidenced a group of agency documents titled "Skilled Nursing Note". The notes from the following dates, signed by employee I, failed to evidence the title of the writer: 10/12/2020, 10/26/2020, 11/2/2020, 11/9/2020, and 11/16/2020.</p> <p>During an interview on 1/20/2021 at 11:50 a.m., the administrator indicated the agency failed to ensure writers' signatures included their title.</p> <p>9. Clinical record review on 1/19/2021 for patient #7, with start of care 4/1/2020 and certification period 9/28/2020 to 11/26/2020, of the skilled nursing notes from the following dates, signed by employee I, failed to evidence the title of the writer: 9/28/2020, 9/30/2020, 10/3/2020,</p>	G1024			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G1024	Continued From page 110 10/7/2020, 10/12/2020, 10/14/2020, 10/16/2020, 10/19/2020, 10/21/2020, 10/24/2020, 10/26/2020, 10/28/2020, 10/31/2020, 11/2/2020, 11/4/2020, 11/6/2020, 11/9/2020, 11/11/2020, 11/13/2020, 11/16/2020, 11/18/2020, 11/21/2020, 11/23/2020, and 11/25/2020.  During an interview on 1/20/2021 at 2:20 p.m., the administrator indicated the agency failed to ensure writers' signatures included their title	G1024			
G1026	17-15-1(a)(7) Retention of records CFR(s): 484.110(c)(1)(2)  Standard: Retention of records. (1) Clinical records must be retained for 5 years after the discharge of the patient, unless state law stipulates a longer period of time. (2) The HHA's policies must provide for retention of clinical records even if it discontinues operation. When an HHA discontinues operation, it must inform the state agency where clinical records will be maintained. This STANDARD is not met as evidenced by: Based on record review and interview, the home health agency failed to retain records for a minimum of 5 years in 1 of 4 discharged records reviewed. (#5)  The findings include:  1. Record review on 1/19/2021, of an agency policy titled "Plan of Treatment-485" dated 1/14/2018, stated " ... Each patient receives an individual written plan of care, including revisions or additions ...."	G1026			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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	
G1026	Continued From page 111 2. Record review on 1/19/2021, of an undated agency policy titled " Medical Records," stated " ... b. Medical records are retained in the home health agency files for seven years after a patient's discharge or death ...."  3. Clinical record review on 1/20/2021 for patient #5, start of care 4/11/2017, evidenced an unsigned agency document titled "Discharge/Transfer Summary" which indicated patient #5 was discharged on 4/26/2020.  Clinical record review for patient #5, evidenced the most recent plan of care was for certification period 11/27/2019 to 1/25/2020. The clinical record failed to evidence the agency retained the most recent plan of care in the patient's clinical record, for the certification periods from 1/25/2020 and his discharge date of 4/26/2020.  During an interview on 1/20/2021 at 11:52 a.m., the clinical manager indicated they had the plan of care and she sent employee B, administrative assistant, to check in the clinical records. When employee B returned, she indicated she was unable to locate the plan of care.	G1026			
E 000	17-15-1(b) Initial Comments  An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102.  Facility IN009912  Provider # 157511	E 000			

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

PRINTED: 02/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>157511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOME HEALTH SERVICES OF GARY INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1281 W RIDGE RD</b> <b>GARY, IN 46408</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
E 000	Continued From page 112 Visit Dates: 1/12/2021 - 1/20/2021  At this Emergency Preparedness survey, Home Health Services of Gary was found to be in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	E 000		