STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G0000	INITIAL COMMENTS This visit was for a Federal home health Recertification and State Re-licensure survey Survey Dates: August 23, 24, 25, 26, and 27, 2021 Partially Extended on August 26, 2021, at 10:50 AM Facility number: 014364 Provider number: 15K168 Current Census: 11 Unduplicated Census last 12 months: 15 These deficiencies reflect State findings cited in accordance with 410 IAC 17.	G0000		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements;	G0574		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G0574	Continued from page 1 (x) All medications and treatments; (xi) Safety measures to protect against injury; (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. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure patients' plan of care included (but not limited to) patient specific interventions, all medications and treatments, and measurable outcomes for 6 of 7 records reviewed (#1, 2, 3, 4, 6, 7) Findings include: Review of an agency policy dated 2/17/2017, titled "Care Plans C-660" indicated "… measurable… goals… [and] specific interventions…" are required on the Plan of Care. Review of an agency policy dated 2/17/2021, titled "Medication Reconciliation C-709" indicated the nurse shall "… review all medications … update the records and the Consumer's plan of care." Clinical record review was completed on 8/23/2021 for patient #1, start of care 7/14/2021, certification period 7/15/2021 - 9/12/2021, with a primary diagnosis of spinal stenosis, lumbar region without neurogenic claudication (narrowing of the spinal canal).	G0574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G0574	Continued from page 2 An agency document titled “Home Health Certification and Plan of Care” for certification period 7/15/2021 – 9/12/2021, indicated “… Client will have an absence or control of pain as evidenced by optimal mobility and activity necessary for functioning and performing ADLs [activities of daily living] by the end of the care period.” The plan of care failed to evidence a measurable goal. During an interview on 8/26/2021 at 3:30 pm, the administrator indicated this would be a measurable goal because they would count the number of times patient refused care. Clinical record review was completed on 8/23/2021 for patient #2, start of care period 2/12/2019, certification period 12/3/2020 – 1/31/2021, with a primary diagnosis of other amnesia. An agency document titled “Home Health Certification and Plan of Care” for certification period 12/2/2020 – 1/31/2021, indicated the goal was to be free of signs and symptoms of infection. The plan of care failed to evidence specific signs and symptoms to ensure it was a measurable goal. During an interview on 8/26/2021 at 3:30 pm, the administrator indicated this was a measurable goal because wounds were addressed, and no signs or symptoms meant there was no infection. Clinical record review was completed on 8/26/2021 for patient #3, start of care period 4/14/2020, certification period 8/7/2021 - 10/5/2021, with a primary diagnosis of legal blindness. An agency document titled “Home Health Certification and Plan of Care” for certification period 8/7/2021 – 10/5/2021 indicated “… maintain optimal joint function, increased mobility and independence in ADLs by the end of the care period.” The plan of care failed to evidence a measurable goal. During an interview on 8/26/2021 at 3:30 pm, the administrator indicated this would be a measurable goal because if the patient was not going to assisted living, that was meeting the goal. Clinical record review was completed on 8/24/2021	G0574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G0574	Continued from page 3 for patient #4, start of care period 2/13/2019, certification period 8/1/2021 - 9/29/2021. A home observation visit was conducted with the administrator/director of nursing on 8/24/2021 at 1:55 PM, with patient # 4. The administrator/director of nursing was observed completing skilled care. The administrator/director of nursing did not assess the wound. She confirmed the wound clinic did not want the agency changing the wound dressing (would be required to assess the wound). Clinical record review was completed on 8/24/2021 for patient #4. An agency document titled “Home Health Certification and Plan of Care” for certification period 8/1/2021- 9/29/2021, indicated orders for the skilled nurse to assess the patient’s wound, and failed to evidence patient specific interventions as the skilled nurse did not perform wound assessments. Further review of the chart contained a physician order dated 7/15/2021, which included an order for an antibiotic for 21 days. An agency document titled “Home Health Certification and Plan of Care” for certification period 8/1/2021 – 9/29/2021, did not include the antibiotic medication. The agency failed to include all medications on the plan of care. During an interview on 8/26/2021 at 3:30 pm, the administrator confirmed the antibiotic should have been included in the Plan of Care. The administrator/director of nursing confirmed she received wound assessment information from the wound clinic and charted that information. Clinical record review was completed on 8/24/2021 for patient #6, start of care period 6/8/2021, certification period 8/7/2021- 10/05/2021, with a primary diagnosis of diabetes. An agency document titled “Home Health Certification and Plan of Care” for certification period 8/7/2021 – 10/05/2021, indicated “Client’s function will maintain at level appropriate for disease but will not deteriorate further.” The plan of care failed to evidence a measurable goal. During an interview on 8/26/2021 at 3:30 pm, the	G0574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G0574	Continued from page 4 administrator indicated this was a measurable goal because maintaining was determined by not requiring nursing home level of care. Clinical record review was completed on 8/24/2021 for patient #7, start of care period 7/21/2021, certification period 7/21/2021 – 9/18/2021, with a primary diagnosis of unspecified dementia without behavioral disturbance. An agency document titled "Home Health Certification and Plan of Care" for certification period 7/21/2021 – 9/18/2021 indicated "… Client will have an absence or control of pain as evidenced by optimal mobility and activity necessary for functioning and performing ADLs …." The plan of care failed to evidence a measurable goal. During an interview on 8/26/2021 at 3:30 pm, the administrator indicated this would be a measurable goal because they tracked patient falls. 410 IAC 17-13-1(a)(1)(b) 410 IAC 17-13-1(a)(1)(C) 410 IAC 17-13-1-(a)(1)(D)(i-xiii)	G0574		
G0608	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to coordinate care in 3 of 5 active cases (#1, 4, 7). Findings include: Review of an agency policy dated 5/10/2021, titled "Coordination of Consumer Services C-360 indicated care conferences should include "… any outside health care providers." Review of an agency policy dated 2/17/2017, titled	G0608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G0608	Continued from page 5 "Clinical Documentation C-680" indicated "…Telephone or other communication with … physicians… health care team… will be documented…" Clinical record review was completed on 8/23/2021 for patient #1, start of care 7/14/2021, certification period 7/15/2021 - 9/12/2021, with a primary diagnosis of spinal stenosis (narrowing of the spinal canal). Review of the "Home Health Aide Note" for 7/22/2021, indicated bathing and dressing tasks were completed with the "therapist" at the assisted living facility. Review of the "Home Health Certification and Plan" for certification period 7/15/2021 – 9/12/2021, failed to evidence information regarding physical therapy for the patient. The clinical record failed to evidence documentation of a case conference or coordination with the physical therapist. During an interview on 8/26/2021 at 3:30 pm, the administrator/director of nursing confirmed the patient received physical therapy. When asked about documenting the coordination, the administrator/director of nursing indicated there is no coordination of care for patients with only home health aide services. Clinical record review was completed on 8/24/2021 for patient #4, start of care period 2/13/2019, certification period 8/1/2021- 9/29/2021, with a primary diagnosis of legal blindness, indicated patient had a wound. The clinical record failed to evidence documentation of a case conference that included the wound clinic. A home observation visit was conducted with the administrator/director of nursing on 8/24/2021, at 1:55 PM, with patient # 4. The administrator/director of nursing failed to assess the wound. She indicated the wound was managed by the wound clinic and they did not want the agency to change the dressing (would be required to assess the wound). Review of documents titled "Skilled Nurse Visit RN [registered nurse] dated 8/10/2021, 8/13/2021, and 8/17/2021, failed to evidence documentation of	G0608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G0608	Continued from page 6 care coordination with the wound clinic. During an interview on 8/26/2021 at 3:30 pm, the administrator/director of nursing confirmed the wound clinic provided wound care for patient #4. She indicated she believed she documented the care coordination, and she would look. Prior to exiting the survey, no supporting documentation was submitted for review. Clinical record review was completed on 8/24/2021 for patient #7, start of care period 7/21/2021, certification period 7/21/2021 – 9/18/2021, with a primary diagnosis of dementia. The clinical record failed to evidence documentation of coordination of care or a case conference with the therapist. A home observation visit was conducted on 8/25/2021 at 12:00 pm with patient #7. During that visit, a “therapy” schedule was observed. During an interview on 8/26/2021 at 3:30 pm, the administrator/director of nursing confirmed patient had occupational therapy. She confirmed she expected documentation of care coordination. 410 IAC-17-14-1(a)(1)(F) 410 IAC-17-12-2(g) 410 IAC-17-14-1(c)(6)	G0608		
G0682	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 agency failed to ensure all staff followed standard precautions and infection control for 1 of 3 home visits observed (#1). Findings include:	G0682		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G0682	Continued from page 7 Review of an agency policy dated 5/10/2021, titled "Hand Washing/Hand Hygiene D-330" indicated "… health care personnel should avoid wearing artificial nails and keep natural nails less than one quarter of an inch long if they care for consumers at high risk of acquiring infections …." Review of an agency policy dated 5/10/2021, titled "Infection Prevention/Control Policy B-403" indicated "… will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention …." Review of the Centers for Disease Control and Prevention (CDC) web page reference, https://www.cdc.gov/handhygiene/providers/index.html, indicated "… Germs can live under artificial fingernails both before and after using an alcohol-based hand sanitizer and handwashing … it is recommended that healthcare providers do not wear artificial fingernails or extensions when having direct contact with patients at high risk …." A home observation visit was conducted with HHA (home health aide) E on 8/25/2021 at 11:05 AM, with patient #1. HHA E was observed with long artificial fingernails. HHA E was observed filing patient fingernails and serving patient a meal. During an interview on 8/25/2021at 3:30 PM, when asked if direct care staff should wear artificial nails when caring for a diabetic patient at high risk for infection, administrator A and president I asked for time for them to discuss and get back with a response. On 8/26/2021 at 3:30 PM, administrator A indicated direct care staff should not wear artificial nails and fingernails should not be long. 410 IAC 17-12-1(m)	G0682		
G0800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law;	G0800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G0800	Continued from page 8 and (iv) Consistent with the home health aide training. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the home health aide (HHA) followed the plan of care for 3 of 4 records reviewed that were assigned home health aides (#1, 2, 6). 1. Review of an agency policy dated 5/10/2021, titled “Home Health Aide Services C-220” indicated “… aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising nurse ….” 2. Review of an agency policy dated 2/17/2017, titled “Care Plans C-660” indicated “… home health aide tasks will be identified on the home health aide care plan with specific instructions ….” 3. Review of an undated agency document titled “Home Health Aide/Hospice Aide Competency Checklist” indicated “… understanding of different types of baths … sponge bath … shower ….” 4. Clinical record review was completed on 8/23/2021 for patient #1, start of care 7/14/2021, certification period 7/15/2021-9/12/2021, with a primary diagnosis spinal stenosis, lumbar region (narrowing of spinal cord in lower back). An agency document titled “Home Health Certification and Plan of Care” dated 7/15/2021, which indicated “… orders … HHA to assist with shower in chair at each visit ….” Clinical record review evidenced an agency document titled “Home Health Care Plan” dated 7/15/2021, that indicated “… shower with chair … at each visit ….” Clinical record review evidenced agency documents titled “Home Health Aide Note” dated 7/15/2021, 8/2/2021 signed by HHA J; dated 7/19/2021, signed by administrator A; dated 7/21/2021, signed by HHA D, identified the completed tasks as chair bath. Agency documents dated 7/20/2021, 7/23/2021 signed by HHA D; dated 7/27/2021 signed by HHA J, identified the completed tasks as chair bath and sponge bath. The home health aide failed to follow the plan of care.	G0800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G0800	Continued from page 9 Agency documents titled "Home Health Aide Note", dated 7/15/21, 7/20/21, 7/21/21, 7/23/21, 7/27/21, and 8/2/21 indicated a chair bath and sponge were completed. During an interview on 8/26/2021 at 3:50 PM, the administrator confirmed a chair bath is given sitting in front of a sink or on a bench in the shower and shower with a chair is the same as a sponge bath. 5. Clinical record review was completed on 8/23/2021 for patient #2, start of care 2/12/2019, certification period 12/3/2020-1/31/2021, with a primary diagnosis amnesia (memory loss). An agency document titled “Home Health Certification and Plan of Care” dated 1/11/2021, indicated “… orders … HHA assist with shower at each visit ….” Clinical record review evidenced an agency document titled “Home Health Care Plan” dated 12/11/2020, which indicated “… shower with chair … applies to all shifts ….” Clinical record review evidenced agency documents titled “Home Health Aide Note” dated 12/15/2020-1/12/2021 for 20 visits, signed by HHA D. The HHA documentation identified the completed tasks was a sponge bath (which failed to follow the plan of care). During an interview on 8/26/2021 at 3:30 PM, when asked if the home health aide should provide a sponge bath that is not in the plan of care, the administrator indicated the agency would expect the HHA to provide some sort of bathing as long as the type of bathing is documented. 6. Clinical record review was completed on 8/26/2021 for patient #6, start of care 6/8/2021, certification period 6/8/2021-8/6/2021 with a primary diagnosis diabetes. An agency document titled “Home Health Certification and Plan of Care” dated 6/8/2021, which indicated “… orders … HHA will assist with shower utilizing shower bench ….” Clinical record review for certification period 8/7/2021-10/5/2021 an agency document titled “Home Health Certification and Plan of Care” dated 8/13/2021, which indicated “… orders … HHA will assist with shower utilizing shower bench at each visit ….”	G0800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G0800	Continued from page 10 Clinical record review evidenced agency documents titled “Home Health Care Plan” dated 6/8/2021 and 8/6/2021, which indicated “… shower with chair … shower bench … applies to all shifts ….” Clinical record review evidenced an agency document titled “Home Health Aide Note” dated 7/29/2021, signed by HHA D. The HHA documentation identified the completed tasks were sponge bath (which failed to follow the plan of care). During an interview on 8/26/2021 at 3:30 PM, when asked if the home health aide should follow the plan of care, the administrator indicated the home health aide should follow the plan of care but will also follow the patient wishes.	G0800		
G0804	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 home health aides reported changes in patient condition to a registered nurse in 1 of 3 active patients with home health aide services (#1). Findings include: Review of an agency policy dated 2/17/2017 and titled “Home Health Aide Services C-220” indicated the Home Health aide (HHA) must report “… observations of the consumer’s condition and reporting results to the Registered Nurse....” The agency failed to evidence aide documentation of a report to the registered nurse of the patient’s condition. Clinical record review was completed on 8/23/2021 for patient #1, start of care 7/14/2021, certification period 7/15/2021 - 9/12/2021, with a primary diagnosis of spinal stenosis, lumbar region without neurogenic claudication (narrowing	G0804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G0804	Continued from page 11 of the spinal canal). Review of an agency document dated 8/4/2021, titled “Home Health Aide Note” included a comment about the patient having dizziness after getting out of bed. Review of an agency document dated 8/9/2021, titled “Home Health Aide Note” included a comment that the patient was confused. Review of an agency document dated 8/16/2021, titled “Home Health Aide Note” included a comment that the patient called the doctor due to pain. Review of an agency document dated 8/20/2021, titled “Home Health Aide Note” included a comment that the patient refused care due to pain. During an interview on 8/26/2021 at 3:30 pm, the administrator/director of nursing confirmed a registered nurse should be notified of confusion, dizziness, pain requiring a call to the doctor, and care refused due to pain.	G0804		
G0946	Administrator appointed by governing body CFR(s): 484.105(b)(1)(i) (i) Be appointed by and report to the governing body; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure there was evidence the Administrator was appointed by and reported to the governing body. 1. Review of an agency job description dated 12/14/2018, titled “Administrator/Alternate Administrator Home Care/Health Care Division” indicated “… reports to: President/CEO … assumes responsibility for overall direction of the administrative affairs … subject to the approval of the President/CEO ….” 2. Review of an agency document dated 8/1/2021, titled “Organizational Chart” indicated the delineation of authority was “… Board of Directors … President/CEO [president/CEO I] … Director Home Health Care Plus [administrator] ….” 3. During an interview on 8/23/2021 at 12:30 PM,	G0946		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G0946	Continued from page 12 when asked administrator who he/she reports to, administrator indicated they reported to the president/CEO of the agency. IAC 410 17-12-1(b)(1)	G0946		
G1030	Retrieval of records CFR(s): 484.110(e) Standard: Retrieval of clinical records. A patient's clinical record (whether hard copy or electronic form) must be made available to a patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first). This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure patient's clinical records would be made available to the patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first). Review of an agency document dated 5/12/2021 titled “Consumer Orientation to Home Health Care Handbook” indicated “… Notice of Privacy Practices for Protected Health Information … what rights you have regarding your medical information … the right to see and get copies of your medical information … we will respond to you within 30 days after receiving your written request … if you request copies of your medical information, we will charge you a reasonable fee ….” Review of an agency policy dated 5/10/2021 titled “Consumer Admission Process Policy C-140” indicated “… admission professional will … provide the consumer with a copy of their privacy rights and the Notice of Privacy Practices ….” Review of an agency policy dated 5/10/2021 titled “Home Care Bill of Rights/Consumer Rights C-380” indicated “… privacy … agency shall advise the consumer or the consumer’s legal/selected representative of its policies and procedures regarding the accessibility of clinical records ….” 4. During an interview on 8/25/2021 at 3:30 PM, when asked if the agency provided the patient with the current information regarding requests for	G1030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE PLUS	5821 SOUTH ANTHONY BLVD , FORT WAYNE, Indiana, 46816

(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
G1030	Continued from page 13 copies of their medical record, the administrator indicated that information was in the orientation handbook. IAC 410 17-12-3(b)(3)	G1030		