PRINTED:	11/26/2019
FORM API	PROVED

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	(X2) MULTIPLE CC A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 10/24/2019			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 302 E NORTH B STREET GAS CITY, IN 46933					
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION			
TAG G 0000	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE			
Bidg. 00	This was a federal survey with one (1	recertification home health ) complaint.	G 0000					
	This survey was as on October 23, 20	nnounced as partially extended 19 at 10:16 AM.						
	Complaint: IN 002 findings	285758; substantiated with						
	Facility #: 013349							
	Provider #: 15K1							
	Medicaid #: 2012							
	Survey dates: Oct Skilled Services:	ober 21, 22, 23, 24; 2019						
	Home Health Aide							
	Total Current Cen	-						
	Record reviews w Record review wit Discharged record Total clinical reco	hout home visits: 2 reviews: 2						
		reflect State findings cited in 10 IAC 17. Refer to State Form e Findings.						
G 0528								
Bldg. 00	Based on record re	eview and interview, the	G 0528	The Administrator and Director of Nursing of Hometown Home	of 11/22/2019			

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPL	ETED
		15K118	B. WING		10/24/2019	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
JAME OF 1	PROVIDER OR SUPPLIE	R		NORTH B STREET		
HOMET	OWN HOME HEAL	THCARE INC	GAS C	ITY, IN 46933		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	-	RN) failed to ensure the		Healthcare have reviewed the		
	-	sessment was accurate and		federal/state policy 484.55(c)(	1)	
	-	current health status for 2 of 7		and Hometown Home Healtho	are	
	patient records rev	iewed (#1,3).		personal policy C-580 Plan of	Care	
				and C-145 Comprehensive cli	ent	
	Findings include:			assessment. The Administrate	or	
				and Director of Nursing had a		
	1. An undated age	ency policy titled,		meeting with RN staff to educate	ate	
	"COMPREHENSI	VE CLIENT ASSESSMENT"		them on proper documentation	n	
	provided on 10/23	/19 at 2:06 PM by the DON		while doing assessments, that		
	(director of nursing	g) stated, " A thorough,		they need to include a comple		
	well-organized, co	mprehensive and accurate		picture of the status of the clie		
	assessment, consis	tent with the client's immediate		including their health,		
	needs will be com	pleted for all		psychosocial, function, and		
	clientsPURPOSI	ETo determine the appropriate		cognition status. Staff reviewe	d	
		l services to meet client initial		the client's cited and clarified t		
	needs To collect	data about the client's health		complete status of the client.		
	history, (physical,	functional and		The RN staff will audit all char	ts as	
	psychological)"			they are updating their		
				assessments and ensure that	all	
	2. The clinical rec	ord of patient #1 was reviewed		aspects of the client's conditio		
		dicated a start of care date of		are met. This included, but no		
		rd contained a plan of care for		limited to, health status,	-	
		priod of 9/29/2019 - 11/27/19, that		psychosocial status, functiona	l	
	-	sis of, but not limited to, insulin		status, cognition, and pain sta		
	dependant diabetes	5.		The RN staff will address all		
	<b>^</b>			diagnoses and ensure that		
	A Recertification of	comprehensive assessment		individual needs/goals are bei	ng	
		ed to address pain description.		met.	5	
		scription of the pain to the		All RN personnel have been		
		noted 'neuropathy', the		in-serviced on the importance	of	
	^	to evidence if the pain was		doing a complete assessment		
		throbbing, ect' as indicated in		ensuring that the client's healt		
		nt. The assessment indicated		status is being documented. F		
	· ·	eived a diabetic foot exam by		personnel will report any chan		
	the RN during the assessment, however, fail			in client condition to the PCP.	-	
	evidence documentation of findings for			The RN staff and QA personn		
		insure the comprehensive		will audit charts for completen		
		ed the patient's current health		to ensure that all assessments		
	status.			are current and accurate.	-	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	g <u>00</u>	_	PLETED	
		15K118	B. WING		10/24/2019		
NAME OF 1	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP ( E NORTH B STREET	COD		
HOMET	OWN HOME HEAL	THCARE INC		S CITY, IN 46933			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE		COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	3. The clinical rec	ord of patient #3 was reviewed					
		dicated a start of care date of					
		rd contained a plan of care for					
		riod of 8/31/2019 - 10/29/19,					
	that indicated a dia seizures and trache	ignosis of, but not limited to, cotomy status.					
		comprehensive assessment					
	dated 8/27/19 failed to evidence any seizure activity, tracheal stoma condition, all tracheal						
suctioning equipment and frequency of suctioning. The RN failed to ensure the							
	comprehensive assessment reflected the patient's current health status.						
	4. During an inter	view on 10/23/19 at 2:00 PM					
	with the DON, she	indicated the comprehensive					
	assessments should	d be accurate and complete.					
	IAC 17-14-1(a)(1)	(B)					
0530							
ldg. 00							
	Deced en un 1		G 0530	The Administrator and		11/22/201	
		eview and interview, the		Nursing of Hometown			
	-	(N) failed to ensure that the		Healthcare have revie			
	-	essment contained individual or 7 of 7 patient records		federal/state policy 48			
	reviewed (#1, 2, 3,	-		and Hometown Home personal policy C-580	Plan of Care		
	Findings include:			and C-145 Comprehe Assessment,. The Adr and Director of Nursin	ministrator		
	1. An undated age	ency policy titled,		meeting with RN staff	-		
	-	VE CLIENT ASSESSMENT"		them on proper docum			
		/19 at 2:06 PM by the DON		while doing assessme			
	-	g) stated, " A thorough,		they need to include a			
		mprehensive and accurate		picture of the status of			
	-	tent with the client's immediate		including client strengt			

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 10/24/2019			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 302 E NORTH B STREET GAS CITY, IN 46933					
HOMET (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C needs will be com clientsPURPOSI care, treatment and needs and his / her care, treatment or information develo and the individual measure processes 2. The clinical rec on 10/23/19 and ir 10/4/18. The reco the certification pe The comprehensiv failed to evidence 3. The clinical rec on 10/22/19 and ir 8/20/19. The reco the certification pe The comprehensiv failed to evidence 4. The clinical rec on 10/22/19 and ir 9/15/16. The reco the certification pe comprehensive ass evidence patient si 5. The clinical rec on 10/22/19 and ir 1/24/18. The reco the certification pe comprehensive ass evidence patient si 6. The clinical rec	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION pleted for all ETo determine the appropriate d services to meet client initial c changing needs To make service decisions based on oped about each client's needs s response to care To cord of patient #1 was reviewed ndicated a start of care date of rd contained a plan of care for eriod of 9/29/2019 - 11/27/19. re assessment dated 9/24/19 patient strengths. cord of patient #2 was reviewed ndicated a start of care date of rd contained a plan of care for eriod of 8/20/2019 - 10/18/19. re assessment dated 8/20/19 patient strengths. cord of patient #3 was reviewed ndicated a start of care date of rd contained a plan of care for eriod of 8/1/19 - 10/29/19. The sessment dated 8/27/19 failed to trengths. cord of patient #4 was reviewed ndicated a start of care date of rd contained a plan of care for eriod of 8/31/19 - 10/29/19. The sessment dated 8/27/19 failed to trengths.	GAS O	CITY, IN 46933  PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) and care preferences. C should be personalized to client and address their concerns/needs. The RN staff will audit al they are updating the assessments and ensure aspects of the client's co are accurate and comple including individual strent goals, and care preferent The RN staff has been in on the importance of contaccurate client assessments personnel will update cliit with any changes in clief condition or areas of contact The RN staff and QA pe will audit charts for completing to ensure that all assesses are current and accurate	ULD BE PROPRIATE ilient goals to the individual Il charts as e that all ondition ete, ngths, nces. n-serviced mplete and ents,. RN ent's PCP nt ncern. rsonnel oleteness sments	(X5) COMPLETIC DATE		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/24/2019 15K118 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 302 E NORTH B STREET HOMETOWN HOME HEALTHCARE INC GAS CITY, IN 46933 SUMMARY STATEMENT OF DEFICIENCIE (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE certification period of 3/8/19 - 5/6/19. The comprehensive assessment dated 3/6/19 failed to evidence patient strengths. 7. The clinical record of patient #6 was reviewed on 10/23/19 and indicated a start of care date of 2/13/19. The record contained a plan of care for the certification period of 6/13/19 - 8/11/19. The comprehensive start of care assessment dated 2/13/19 failed to evidence patient strengths. 8. The clinical record of patient #7 was reviewed on 10/23/19 and indicated a start of care date of 10/24/18. The record contained a plan of care for the certification period of 8/20/19 - 10/18/19. The comprehensive assessment dated 8/15/19 failed to evidence patient strengths. 9. During an interview on 10/23/19 at 2:00 PM with the DON, she indicated the comprehensive assessments should be accurate and complete. G 0574 Bldg. 00 G 0574 The Administrator and Director of 11/22/2019 Based on observation, record review and Nursing of Hometown Home interview, the agency failed to ensure the plan of Healthcare have reviewed the care (POC) included measurable goals, home federal/state policy 484.60(a)(2) health aide (HHA) visit frequencies, diagnoses, (I-xvi) and Hometown Home safety measures, specific medication and Healthcare personal policies treatment directions, and durable medical C-580 Plan of Care and C-145 equipment (DME) for 7 of 7 records reviewed (#1, **Comprehensive Client** 2, 3, 4, 5, 6, 7). Assessment. The Administrator and Director of Nursing had a Findings include: meeting with RN staff to educate them on proper documentation 1. A current, undated agency policy titled, "Plan while doing assessments. These of Care" stated, "...PURPOSE ... To reflect client's assessments need to ensure that ability to make choices and actively participate in the plan of care included CVFL11 Event ID: Facility ID: 013349 If continuation sheet Page 5 of 38 FORM CMS-2567(02-99) Previous Versions Obsolete

11/26/2019

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COM	PLETED
		15K118	<b>B</b> . W	NG	<u></u>	10/24/2019	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	2R		302 E 1	NORTH B STREET		
HOMET	OWN HOME HEAL	THCARE INC		GAS C	ITY, IN 46933		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	DN	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	establishing and for	blowing the plan designated to			measurable goals, visit		
	attain personal hea	lth goalsSPECIAL			frequencies, diagnoses, sa	fety	
	INSTRUCTIONS	1. An individualized Plan of			measures, specific medica	-	
	Care shall be re-	quired for each client 2. The			and treatment directions, a		
		be completed in full to include:			durable medical equipment		
		ignoses c. Type, frequency,			RN and QA personnel revie		
	-	visits/ services l.			charts to ensure that		
		ments, and procedures			medication/treatment profil	es were	
		ind equipment required p.			complete, accurate, and in		
		u. All of the above items must			layman's terms. All		
		ed on the Plan of Care"			medication/treatment profil	ac wara	
	always be address	ed on the Flan of Care			re-written to be complete,		
	2 The clinical rec	cord of patient #1 was reviewed				ormo	
		dicated a start of care date of			accurate, and in layman's t		
					Updated medication/treatm		
		rd contained a plan of care for			profiles were then delivered		
	-	eriod of 9/29/2019 - 11/27/19 that			client homes and placed in		
	-	es of, but not limited to,			binders. Measurable goals		
		ic obstructive pulmonary			developed for the client's v		
		The POC indicated home health			frequencies were updated		
		orders of 4-6 hours / day, 5 -7			each plan of care, diagnosi	s were	
		A visits for the week of 9/29/19			reviewed to ensure that all		
		ed the patient received HHA			diagnoses were documente		
		a day, 1-4 hours each visit for 7			safety measures were iden		
	2	led to evidence measurable			and all durable medical equ	uipment	
	e	abetes or COPD and HHA			was verified for accuracy.		
	specific visit frequ	encies.			RN staff has been in-service	ed that	
					all plan of cares include		
		cord of patient #2 was reviewed			measurable goals, home h	ealth	
		ndicated a start of care date of			aide visit frequencies, diag	noses,	
		rd contained a plan of care for			safety measures, specific		
	the certification pe	eriod of 8/20/2019 - 10/18/19 that			medication and treatment		
	indicated diagnose	es of, but not limited to, cerebral			directions, and durable me	dical	
	palsy, convulsions	and urinary incontinence. The			equipment identified prope	rly.	
	POC indicated the	patient had external catheters			The RN staff and QA perso	-	
	and an 18f Micke	y button (type of gastrostomy			will audit charts for comple		
		iled to evidence measurable			to ensure that all assessme		
		nvulsions and risk of infection			are current and accurate.		
	-	zations. The POC failed to					1
		outton specific instructions for					
		how often it was to be changed.					
	since specifies and						1

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	(X2) MULTIPLE ( A. BUILDING B. WING	<u>00</u>	COM	(X3) DATE SURVEY COMPLETED 10/24/2019	
	NAME OF PROVIDER OR SUPPLIER HOMETOWN HOME HEALTHCARE INC			r address, city, state, zip ( NORTH B STREET CITY, IN 46933	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
	DON indicated the #2's POC were an and out catheteriza (french) straight ca 4. The clinical rec on 10/22/19 and ir 9/15/16. The reco the certification pe indicated diagnose neuromuscular dys tracheostomy statu patient had DME i ambu bag. The PC medications, not li (respiratory medic needed via trach, f (drops) twice daily ml (milliliters) twi sodium nitrate 30 The POC failed to instructions related medications provide evidence measural infection related to status. On 10/22/19 at 1:5	and of patient #3 was reviewed dicated a start of care date of rd contained a plan of care for striod of 8/31/19 - 10/29/19 that as of, but not limited to, sfunction of the bladder and is. The POC indicated the neluding, but not limited to, iC indicated the following mited to: albuterol 0.083% ation), 1 vial every 4 hours as lucinolone oil 0.01%, 5 gtts v to affected ear, gentamicin 10 ce daily via (by) straight cath, ml twice daily via straight cath. evidence specific medication i to administration of all ded to the patient and failed to oble goals related to risk of o catherizations and respiratory					
	patients' travel bag ambu. During an i D indicated this w had ever had. The dated as initiated of	ent #3's home, observed in the g, an ambu labeled as an infant interview at that time, employee as the only ambu the patient patients' medication profile on 9/15/16 indicated the patient tall and 115 pounds.					
		ord of patient #4 was reviewed dicated a start of care date of					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/24/2019 15K118 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 302 E NORTH B STREET HOMETOWN HOME HEALTHCARE INC GAS CITY, IN 46933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 1/24/18. The record contained a plan of care for the certification period of 9/16/19 - 11/14/19 that included diagnoses of intellectual disabilities and major depressive disorder. The POC failed to evidence measurable goals or safety strategies related to any behaviors to assist the staff during care or depression. 6. The clinical record of patient #5 was reviewed on 10/22/19 and indicated a start of care date of 1/7/19. The record contained a plan of care for the certification period of 3/8/19 - 5/6/19 that indicated diagnoses of, cerebral palsy, major depressive disorder, gastro-esophageal reflux, unspecified mood disorder, back pain and migraine headache. The comprehensive assessment dated 3/6/19 indicated the patient also experienced PTSD (post traumatic stress disorder) and anxiety. The POC failed to evidence the diagnoses of PTSD and anxiety and failed to evidence measurable goals related to depressive disorder and pain. 7. The clinical record of patient #6 was reviewed on 10/23/19 and indicated a start of care date of 2/13/19. The record contained a plan of care for the certification period of 6/13/19 - 8/11/19 that included diagnoses of, but not limited to, autistic disorder, anxiety and epilepsy. The POC failed to evidence measurable goals or safety strategies related to any behaviors to assist the staff during care, epilepsy, or anxiety. 8. The clinical record of patient #7 was reviewed on 10/23/19 and indicated a start of care date of 10/24/18. The record contained a plan of care for the certification period of  $\frac{8}{20}$  -  $\frac{10}{18}$  +  $\frac{10}{18}$  +  $\frac{10}{18}$ indicated diagnoses of, but not limited to, disorders of the lung, low back pain, abnormality of gait, and type 2 diabetes. The medication CVFL11 Facility ID: 013349 Page 8 of 38 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	î î	ILDING NG	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/24/2019	
	PROVIDER OR SUPPLIE OWN HOME HEAL			302 E I	ADDRESS, CITY, STATE, ZIP COD NORTH B STREET ITY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
G 0614 Bldg. 00	<ul> <li>patient received a to evidence the use to evidence measu diabetes or pain.</li> <li>9. During an inter with the DON, she assessments should IAC 17-13-1(a)(1) IAC 17-13-1(a)(1) IAC 17-13-1(a)(1)</li> <li>Based on observat interview, the ager visit schedule was caregivers for 2 or Findings include: <ol> <li>During a home E, registered nurse at patient #2's hom patient's home hea failed to evidence agency.</li> <li>On 10/22/19 at 8:3 asked if the visit schedule Employee E is her</li> <li>During a home D, licensed practice</li> </ol> </li> </ul>	(C) (D)(ii)(iii)(ix)(x) ion, record review and acy failed to ensure a written provided to the patient and f 3 home visits observed (#2, 3). visit observation with Employee (RN), on 10/22/19 at 8:00 AM, e (start of care 8/20/19), the lth folder was observed and it a visit schedule provided by the 0 AM, the Employee E, RN was chedule was in the home. The d it was not. The DON stated,	G 04	514	The Administrator and Directon Nursing of Hometown Home Healthcare has reviewed the federal/state policy 484.60(e)( requiring a visit schedule to be available in the client's home. Updated schedules were delive to each client. The scheduler contacted client to verify that they had an update visit schedule, replacing schedules as needed. The scheduler sends client schedul with staff each month to be plate in the client's home. The employees will be remind monthly that the client's schedules need to be placed if the client's home where the cl has access to them. Employee will sign for client schedules, acknowledging that they are responsible for placing the	1) erered t's ated eles aced ed n ient	11/22/2019

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		15K118	B. WING			10/24	/2019
NAME OF I	PROVIDER OR SUPPLIE	R	-		ADDRESS, CITY, STATE, ZIP COD		
	OWN HOME HEAL				NORTH B STREET ITY, IN 46933		
					1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	7	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	ÎATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		nt's home health folder was			schedules in the client's hon	-	
		led to evidence a visit schedule			RN staff will verify placemer	t of	
	provided by the ag	ency.			schedules with each visit to		
	$Om \frac{10}{22}/10 \text{ at } 1.1$	5 DM Employee D. I. DN wee			ensure compliance.		
		5 PM, Employee D, LPN was tient's visit schedule was.					
	Employee D stated						
	2 0 10/22/10 /	1.00 DM (1. DOM ( / 1. 11)					
		1:20 PM, the DON stated, "I will e." when asked the whereabouts					
	of the patient's visi						
	of the patient's visi	t schedule.					
G 0616							
Bldg. 00							
-			G 00	616	The Administrator and Direc	tor of	11/15/201
		ion and interview, the agency			Nursing of Hometown Home		
		at a medication list was			Healthcare reviewed the		
		ient and was put into laymans			federal/state policy 484.60(e	)(2)	
		sy for the patient to understand			requiring accurate client		
	for 2 of 3 home vis	sits observed (#2,3).			medication		
					schedules/instructions, to be		
	Findings include:				layman's terms in the client's home. The medication list of		
	1. During a home	visit observation with Employee			plan of care has already bee		
	-	(RN), on 10/22/19 at 8:00 AM,			updated into layman's terms		
		e (start of care $8/20/19$ ), the			medication/treatment profile		
	<u>^</u>	Ith folder was observed and it			updated to be specific and in		
	-	a medication list written			layman's terms with a copy		
		hans terms that was easy to			provided to the client for	99	
		ovided by the agency to the			placement in their binder.		
	patient's caregivers				The client charts were all au	dited	
					and medication/treatment pr	ofiles	
		visit observation with Employee			were updated to be specific	and in	
	-	al nurse (LPN), on 10/22/19 at			layman's terms for the client	and	
	-	t #3's home (start of care			family to be able to understa	nd.	
		nt's home health folder was			Copies were then sent to the	;	
		led to evidence a medication			client's home for placement	in	
	-	tely in laymans terms that was			their binder.		
	easy to understand	, was provided by the agency			Medication profiles will be		
	1		1				1

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA			NETRICTION	-	1B NO. 0938-039
	VT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/24/2019	
	PROVIDER OR SUPPLIE		•	302 E N	DDRESS, CITY, STATE, ZIP COD ORTH B STREET TY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
G 0682	director of nursing	w on 2/19/19 at 3:30 PM, the stated a current medication list atient's home folder.			monitored for accuracy and to ensure it is written in layman's terms with each RN visit. RN s has been educated on importa of making medication/treatment profile complete, accurate, and easy to understand. Charts will be audited under th QAPI program to ensure that to medication/treatment profiles a complete, accurate, and easy understand. A minimum of 10 <sup>o</sup> charts will be audited monthly.	staff ance nt d he are to % of	
Bldg. 00	interview, the agen followed infection precautions for 1 of Employee D) Findings include: An undated, agend PREVENTION / O on 10/23/19 at 10: To ensure employed the risk of transmi from both recognition of infection"		G 00	582	The Administrator and Directo Nursing of Hometown Home Healthcare have reviewed the federal/state policy 484.70(a) a Hometown Home Healthcare personal policy D-330 Handwashing/Hand Hygiene staff was re-educated by way Handwashing in-service of the proper way to wash hands, an how long hands should be washed. The Director of Nursing in-service all staff with Handwashing in-service to ensure there were questions about how long han were to be washed and proper procedure for doing so.	and All of d for viced e no ds	11/15/201
	by the DON on 10 HAND HYGIEN washing hands wit	G / HAND HYGIENE" provided /22/19 at 2:00 PM stated, " VE TECHNIQUE 2. When h soap and water, wet hands oply an amount of product			All staff will be in-serviced upon hire and yearly on infection co and hand hygiene to ensure the they are up to date with all procedures to prevent infection	ntrol nat	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED 10/24/2019	
	ROVIDER OR SUPPLIE			302 E I	ADDRESS, CITY, STATE, ZIP COD NORTH B STREET ITY, IN 46933		
(X4) ID		STATEMENT OF DEFICIENCIE			1		(X5)
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	]	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	COMPLETION DATE
	hands together vig seconds, covering fingers" During a home vis 1:50 PM with patie employee D, obser on, assist the patie The employee app the patient and wa gloves, turned on v soap and performe wash under runnin turned off the wate hands and followe towels. During an intervie the DON, she india	nanufacturer to hands and rub orously for at least fifteen (15) all surfaces of hand and it observation on 10/22/19 at ent #3 (start of care 9/15/16) with ved the employee with gloves int to bed and removed brief. lied a clean brief and pants to ked to the bathroom, removed vater, rinsed hands, applied d a seven (7) second hand g water. The employee then er with the back of her wet d by drying hands with paper w on 10/24/19 at 1:00 PM with cated staff should be washing ds if using soap and water.			cross contamination. QAPI will continue to monitor at track all illness's in client's and caregivers to determine if there a common underlying cause an to ensure there is no cross contamination between client's and caregivers.	e is nd	
G 0798 Bldg. 00							
	interview, the regi- ensure that an aide each shift for the l failed to ensure that individualized, and followed the aide of	ion, record review, and stered nurse (RN) failed to care plan was completed for nome health aide (HHA) and at the aide care plan was I failed to ensure that the aides care plan for 3 of 5 records ts who received HHA services.	G 07	798	The Administrator and Director Nursing of Hometown Home Healthcare have reviewed the federal/state policy 484.(g)(1) a Hometown Home Healthcare personal policy C-751 Home Health Aide Care Plan. The Director of Nursing updated the client care plans to be shift specific and to be specific on th care that was to be provided. The RN staff audited all charts reviewed the individual care pla	and e ne and	11/15/2019

	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION					
	OF CORRECTION	IDENTIFICATION NUMBER	. ,	JILDING	<u>00</u>	(X3) DATE SURVEY COMPLETED		
		15K118	B. W.		<u></u>		4/2019	
NAME OF		D.		STREET	ADDRESS, CITY, STATE, ZIP COD			
	PROVIDER OR SUPPLIE				NORTH B STREET			
HOMET	OWN HOME HEAL	THCARE INC		GAS C	ITY, IN 46933			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	PRIATE	COMPLETI	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	-	ncy policy titled, "HOME			All care plans were update			
		ARE PLAN" provided by			shift specific and day spec			
		" POLICY; A complete and			required tasks. RN staff the			
		lan, identifying duties to be			educated HHA staff that ca			
		Home Health Aide, shall be			plans had been updated a			
	developed by a Re	gistered Nurse"			ensure that they look at ca			
	2 The distant	and after the strengt #1 and strengt in the			each time they are in the h			
		ord of patient #1 was reviewed			Care plans were developed	d with		
		dicated a start of care date of			client involvement.			
		rd contained a plan of care			The RN staff, with every ac			
		fication period of 9/29/19 - eated home health aide (HHA)			and recertification assess			
					will review the care plan wi			
		ours per day, 5 - 7 days per personal care, activities of			client, develop it to meet th			
		's), and light housekeeping.			client's individual needs wi	•		
	ually living, (ADL	s), and fight housekeeping.			from client, and place it in l for HHA staff to look at and			
	The HHA wight sch	edule evidenced for the week			reference each time they a			
		9 as well as on 10/6/19 and			the home. If there are more			
		performed visits 1 - 2 times			one visit in a given day, the			
		ach shift for 7 days. The HHA			be a care plan tailored for			
		e patient's mobility as follows to			shift the client has care.			
		by the HHA: Ambulation			The RN staff and QA perso	nnel		
		heelchair / Cane and the			will audit charts for comple			
		formed daily as needed: Tub /			presence of care plan for e			
		ir Partial / Complete, perineal			shift. Care plans will be up			
		Elimination, Light housekeeping			as the clients needs chang			
		is completed. The HHA POC			minimum of 10% of charts			
	· ·	owing to be completed as			audited each month.			
		The HHA POC failed to						
		ssistive device the patient was						
		on and the specific type of bath						
		hed and failed to identify what						
	-	visit or once a week for example)						
	the tasks were to b	- · ·						
	2 The alignet	and of notions #4 was not						
		ord of patient #4 was reviewed						
		dicated a start of care date of						
		rd contained a POC for the $11/14/10$ that						
	-	1  of  9/16/19 - 11/14/19  that						
	indicated HHA fre	quency of 4 -6 hours per day, 4						

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	A. B	UILDING	DNSTRUCTION 00	CO	ate survey Mpleted /24/2019
	PROVIDER OR SUPPLIE OWN HOME HEAL			302 E N	ADDRESS, CITY, STATE, ZIP NORTH B STREET ITY, IN 46933	COD	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	-	assist with personal care, iving, (ADL's), and light					
	of 9/15/19 - 9/21/1	edule evidenced for the week 9 the HHA performed visits 2 ours each shift for 6 days.					
	of 9/22/19 - 9/28/1	edule evidenced for the week 9 the HHA performed visits 2 ours each shift for 6 days.					
	of 9/29/19 - 10/5/1	edule evidenced for the week 9 the HHA performed visits 2 ours each shift for 6 days.					
	of 10/1/19 - 10/12	redule evidenced for the week /19 the HHA performed visits 2 ours each shift for 6 days.					
	of 10/13/19 - 10/1	edule evidenced for the week 9/19 the HHA performed visits 2 ours each shift for 6 days.					
	to be performed as Chair Partial / Cor shave, nail care per housekeeping afte The HHA POC fai of bath that was to failed to identify v	epared by the RN evidenced the needed by the HHA: Bed / nplete (in reference to bathing), rineal care, meal prep and light r personal care is completed. led to specify the specific type be performed as needed and what timeframe (every visit or cample) the tasks were to be					
	on 10/22/19 and ir 1/7/19. The record certification period	ord of patient #5 was reviewed dicated a start of care date of d contained a POC for the d of 3/8/19 - 5/6/19 that indicated E4 -6 hours per day, 5 -7 days a					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/24/2019 15K118 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 302 E NORTH B STREET HOMETOWN HOME HEALTHCARE INC GAS CITY. IN 46933 SUMMARY STATEMENT OF DEFICIENCIE (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE week to assist with personal care, ADL's, transfer, medication reminders, meal prep and light housekeeping. The HHA visit schedule from 3/5/19 - 4/10/19 evidenced the HHA performed visits 1 -2 times daily for 1 - 3 hours each shift. The HHA POC prepared by the RN evidenced the to be performed daily by the HHA, to include but not limited to: Bed / Chair Partial / Complete (in reference to bathing), shave, nail care perineal care, meal prep and light housekeeping after personal care is completed. The HHA POC failed to specify the specific type of bath that was to be performed as needed and failed to identify what timeframe (every visit or once a week for example) the tasks were to be completed. IAC 17-14-1(m) G 0962 Bldg. 00 G 0962 The Administrator and Director of 11/22/2019 Based on record review and interview, the clinical Nursing of Hometown Home manager agency failed to ensure all members on Healthcare have reviewed the health care team coordinated care with other federal/state policy 484.105(c)(2) agencies who also provided care for the patient and Hometown Home Healthcare for 2 of 7 patients reviewed (#3, 7). personal policy C-360 Coordination of Client Services. Findings include: The Administrator and Director of Nursing had a meeting with RN 1. On 10/21/19 at 10:37 AM, during the entrance staff and QA personnel to ensure conference the director of nursing (DON) and the that care coordination is being administrator were asked if the agency shares any conducted between our agency and any outside agency the client patients with another agency. Both the DON and the administrator stated, "No." receives services from. Charts were audited to ensure 2. The clinical record of patient #3 was reviewed care coordination is being CVFL11 Event ID: Facility ID: 013349 Page 15 of 38 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/26/2019

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	DNSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMP	LETED
		15K118	B. WI	IG		10/24/2019	
JAME OF	PROVIDER OR SUPPLIE	<sup>T</sup> R			ADDRESS, CITY, STATE, ZIP COD		
	OWN HOME HEAL			GAS C	ITY, IN 46933		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		dicated a start of care date of			completed with all clients. Up		
		cal record contained a plan of			recertification, QA personnel i	S	
		certification period of 8/31/19 -			sending out care coordination	form	
		ed to indicate the patient			with a copy of our plan of care	e to	
	received care or se	ervices from another agency.			each agency the client receive	es	
					services from. The outside ag	ency	
	Agency document	s dated 1/2/19, 2/5/19, 3/5/19,			is responsible for ensuring that	at	
	4/2/19, 5/7/19, 6/4	/19, 7/2/19, 8/6/19, titled, "Case			forms are went out and receiv	ed in	
	Conference / Care	Coordination Note" stated,			a timely manner. Care		
	"Other Agencies /	Services Provided / Hrs:			Coordination is completed wit	h	
	[Name of Agency]	for respite skilled nurse			every recertification assessme	ent	
	services " The d	ocument failed to identify			and any time there is a chang		
	person or persons	at the other agency to whom			with client's condition or service		
	coordination was p				being provided.		
					QA personnel will send		
	3. The clinical rec	ord of patient #7 was reviewed			coordination of care forms an	d	
		dicated a start of care date of			plan of care to all outside		
	10/24/18. The rec	ord contained a plan of care for			agencies with every recertification	ation	
		eriod of 8/20/19 - 10/18/19, that			assessment. QA personnel w		
	-	74 y/o female living alone with			ensure that response is received		
		giver" The POC failed to			from all outside agencies in a		
		nt lived in an assisted living			timely manner.		
	facility.				RN staff and QA personnel w	ill	
					audit charts to ensure coordin		
	The Recertification	n Comprehensive assessment			of care is being completed. A	allon	
		ed to evidence the patient lived			minimum of 10% of charts wil	lhe	
	in an assisted livin	-			audited monthly to ensure		
					compliance.		
	An agency docum	ent dated 10/1/19, titled, "Case					
		Coordination Note" stated, "					
		er Silver birch" The					
	_	identify person or persons at					
		lity to whom coordination was					
	performed.	inty to whom coordination was					
		ent dated 9/3/19, titled, "Case					
		Coordination Note" stated, "					
	-	er Silver birch" The					
		identify person or persons at					
	assisted living faci	lity to whom coordination was					

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	) DATE SURVEY COMPLETED 10/24/2019
	PROVIDER OR SUPPLIE OWN HOME HEAL		302 E I	ADDRESS, CITY, STATE, ZIP COD NORTH B STREET CITY, IN 46933	
(X4) ID PREFIX TAG	(EACH DEFICIE)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	patient #3 and pati coordinate care for	1:20 PM, the DON was asked if ent #7 had written contracts to the patients between them and ne DON indicated the agency			
G 0978					
Bldg. 00	<ul> <li>failed to ensure all team had a written agencies who prov 7).</li> <li>Findings include: <ol> <li>On 10/21/19 at conference the dire administrator were patients with anoth the administrator s</li> <li>The clinical rec on 10/22/19 and im 9/15/16. The clini care (POC) for the 10/29/19, that faile received care or se</li> <li>Agency documents 4/2/19, 5/7/19, 6/4. Conference / Care "Other Agencies / [Name of Agency]</li> </ol></li></ul>	eview and interview, the agency members on the health care agreement for care with other ided care for 2 of 7 patient (#3, 10:37 AM, during the entrance ector of nursing (DON) and the easked if the agency shares any ner agency. Both the DON and tated, "No." ord of patient #3 was reviewed dicated a start of care date of cal record contained a plan of certification period of 8/31/19 - ed to indicate the patient rvices from another agency. s dated 1/2/19, 2/5/19, 3/5/19, /19, 7/2/19, 8/6/19, titled, "Case Coordination Note" stated, Services Provided / Hrs: for respite skilled nurse ocument failed to identify	G 0978	The Administrator and Director of Nursing for Hometown Home Healthcare have reviewed federal/state policy 484.105(e)(2) (I-iv) and Hometown Home Healthcare personal policy C-360 Coordination of Client Services. The Administrator and Director of Nursing had a meeting with RN staff and QA personnel to ensure that care coordination is being conducted between our agency and any outside agency the clien receives services from. Hometow Home Healthcare will have a written agreement for care with shared agencies. All charts were audited to ensure that accurate coordination of care was being conducted with all agencies. Contact was made to ensure that all outside agencies were aware of the services we were providing. QA personnel will ensure that contracts are drawn up between Hometown Home Healthcare and	t m

### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/24/2019 15K118 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 302 E NORTH B STREET HOMETOWN HOME HEALTHCARE INC GAS CITY, IN 46933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE person or persons at the other agency to whom any company we hire to complete coordination was performed. services for us. QA personnel will ensure that care coordination is 3. The clinical record of patient #7 was reviewed completed with said companies. on 10/23/19 and indicated a start of care date of Hometown Home Healthcare will 10/24/18. The record contained a plan of care for retain the overall responsibility for the certification period of $\frac{8}{20}$ - $\frac{10}{18}$ , that all services being provided stated, "Client is a 74 y/o female living alone with under this agreement. not available caregiver ...." The POC failed to RN staff and QA personnel will evidence the patient lived in an assisted living audit 10% of charts every month facility. to ensure tht care coordination is being completed. The Recertification Comprehensive assessment dated, 8/15/19 failed to evidence the patient lived in an assisted living facility. An agency document dated 10/1/19, titled, "Case Conference / Care Coordination Note" stated, "... Participants:... Other Silver birch ...." The document failed to identify person or persons at assisted living facility to whom coordination was performed. An agency document dated 9/3/19, titled, "Case Conference / Care Coordination Note" stated, "... Participants:... Other Silver birch ...." The document failed to identify person or persons at assisted living facility to whom coordination was performed. 4. On 10/24/19 at 1:20 PM, the DON was asked if patient #3 and patient #7 had written contracts to coordinate care for the patients between them and other agencies. The DON indicated the agency did not. IAC 17-12-2(h) G 1016 CVFL11 Facility ID: 013349 Page 18 of 38 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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### PRINTED: 11/26/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15K118 B. WING 10/24/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 302 E NORTH B STREET HOMETOWN HOME HEALTHCARE INC GAS CITY, IN 46933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Bldg. 00 G 1016 The Administrator and Director of 11/22/2019 Based on record review and interview, the plan of Nursing for Hometown Home

Healthcare have reviewed

personal policy C-145 Comprehensive Client

federal/state policy 484.110(a)(3) and Hometown Home Healthcare

Assessment. The Administrator

meeting with RN staff to ensure

and Director of Nursing had a

care failed to evidence patient identified-goals for

"COMPREHENSIVE CLIENT ASSESSMENT"

provided on 10/23/19 at 2:06 PM by the DON

1. An undated agency policy titled,

Findings include:

7 of 7 patient records reviewed (#1, 2, 3, 4, 5, 6, 7).

	provided on 10/25/19 at 2:00 1 th by the Dort		incoming with the star to chourd	
	(director of nursing) stated, " A thorough,		that each client has individual,	
	well-organized, comprehensive and accurate		measureable goals.	
	assessment, consistent with the client's immediate		All charts were audited to identify	
	needs will be completed for all		client's who need goals updated.	
	clientsPURPOSETo determine the appropriate		Goals were developed with each	
	care, treatment and services to meet client initial		client that were personalized and	
	needs and his / her changing needs To make		measurable.	
	care, treatment or service decisions based on		QA personnel will audit all	
	information developed about each client's needs		recertification assessments for	
	and the individuals response to care To		personalized, measurable goals,	
	measure processes of care"		before plan of care is sent to MD	
			for signature.	
	2. The clinical record of patient #1 was reviewed		10% of charts will be audited	
	on 10/23/19 and indicated a start of care date of		monthly to ensure that each client	
	10/4/18. The record contained a plan of care for		has individual, measurable goals.	
	the certification period of $9/29/2019 - 11/27/19$ .		QAPI will monitor the progress	
	The POC (plan of care) failed to evidence patient -		towards goals with each quarterly	
	identified goals.		meeting, more often if necessary.	
	3. The clinical record of patient #2 was reviewed			
	on 10/22/19 and indicated a start of care date of			
	8/20/19. The record contained a plan of care for			
	the certification period of $8/20/2019 - 10/18/19$ .			
	The POC failed to evidence patient - identified			
	goals.			
	4. The clinical record of patient #3 was reviewed			
	on 10/22/19 and indicated a start of care date of			
	9/15/16. The record contained a plan of care for			
FORM CMS-2567(0	2-99) Previous Versions Obsolete Event ID: C	VFL11 Facility	v ID: 013349 If continuation sheet	Page 19 of 38
1 51001 61015 2507(0				. ago 10 01 00

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/24/2019 15K118 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 302 E NORTH B STREET HOMETOWN HOME HEALTHCARE INC GAS CITY, IN 46933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the certification period of 8/31/19 - 10/29/19. The POC failed to evidence patient - identified goals and preferences for care. 5. The clinical record of patient #4 was reviewed on 10/22/19 and indicated a start of care date of 1/24/18. The record contained a plan of care for the certification period of 9/16/19 - 11/14/19. The POC failed to evidence patient - identified goals. 6. The clinical record of patient #5 was reviewed on 10/22/19 and indicated a start of care date of 1/7/19. The record contained a plan of care for the certification period of 3/8/19 - 5/6/19. The POC failed to evidence patient - identified goals. 7. The clinical record of patient #6 was reviewed on 10/23/19 and indicated a start of care date of 2/13/19. The record contained a plan of care for the certification period of 6/13/19 - 8/11/19. The POC failed to evidence patient - identified goals. 8. The clinical record of patient #7 was reviewed on 10/23/19 and indicated a start of care date of 10/24/18. The record contained a plan of care for the certification period of 8/20/19 - 10/18/19. The POC failed to evidence patient - identified goals. 9. During an interview on 10/23/19 at 2:00 PM with the DON, she indicated the plans of care and comprehensive assessments should be accurate and complete. G 1028 Bldg. 00 G 1028 The Administrator and Director of 10/25/2019 Based on observation and interview, the agency Nursing of Hometown Home failed to ensure clinical records were secure at all Healthcare reviewed federal/state times to maintain the privacy of patient policy 484.110(d) protection of CVFL11 Page 20 of 38 Event ID: Facility ID: 013349 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/26/2019

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (X 00	(X3) DATE SURVEY COMPLETED 10/24/2019	
	PROVIDER OR SUPPLIER		302 E	ADDRESS, CITY, STATE, ZIP COD NORTH B STREET		
HOMET (X4) ID PREFIX TAG	<ul> <li>(EACH DEFICIEN REGULATORY OF information in the a agency.</li> <li>Findings include:</li> <li>On 10/22/19 at 10:2 visit to the branch of standing in the cent open office door the cabinet that contain clearly visible. No cabinet in the open</li> <li>On 10/22/19 at 10:2 was leaving and wa The DON left the of door open.</li> <li>On 10/22/19 at 103 the patient files are Employee N, Empl access to the files.</li> <li>On 10/22/19 at 10:2 office. The filing c</li> <li>On 10/22/19 at 10:4 the director of nurs cabinet was suppos ensure visitors are to names. She stated, asked if the cabinet patient information</li> </ul>	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION agency's branch office for 1 of 1 27 AM, during an observation office in Muncie, while er of the branch, observed an at contained an open filing ed the files with patient names lock was observed on the filing office. 33 AM, the DON indicated she is going to the parent branch. ffice door and the filing cabinet 5 AM, Employee M indicated not kept locked and she, oyee I, and the DON all had 36 AM, the DON returned to her abinet remained open. 40 AM, during an interview with ing (DON), she indicated the ed to be closed and locked to mable to see the patient "I guess I left it open." When had a lock to secure the , the DON indicated the filing e a lock and the office door	GAS C ID PREFIX TAG	ITY, IN 46933 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) records and held a meeting with all office staff regarding the security of the client charts. A lock was purchased and placed the chart cabinet. All charts are kept in the chart cabinet. Cabinet is to be closed and locked when charts are not use. Office has been rearranged so charts are not visible from doorway, a lock has been purchased and is in place on the chart cabinet. Office staff is responsible for ensuring that cabinet is locked at the end of th day. The Administrator and Director of Nursing will conduct spot checks to ensure that the cabinet is beir locked and the charts are secure	on in e he of s ng	
I 0000						

PRINTED:	11/26/2019
FORM AP	PROVED
OMB NO. (	)938-039

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15K118 B. WING 10/24/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 302 E NORTH B STREET HOMETOWN HOME HEALTHCARE INC GAS CITY, IN 46933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Bldg. 00 N 0000 This was a visit for recertification and state re-licensure survey with one (1) complaint. Complaint: IN 00285758; substantiated with findings Facility #: 013349 Provider #: 15K118 Medicaid #: 201213550 Survey dates: October 21, 22, 23, 24; 2019 Active Patients: 50 Unduplicated census: 36 Record Review with Home Visit: 3 Record Review without home visit: 2 Discharged Record review: 2 Total records reviewed: 7 Total home visits: 3 N 0456 410 IAC 17-12-1(e) Home health agency Bldg. 00 administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. N 0456 The Administrator and Director of 11/22/2019 Based on record review and interview, the Nursing of Hometown Home agency's governing body failed to ensure the Healthcare have reviewed QAPI program identified clinical concerns, was federal/state policy 410 IAC CVFL11 Page 22 of 38 Event ID: Facility ID: 013349 If continuation sheet State Form

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN		COMPLETED	
	or conduction	15K118	B. WING	<u>.</u>	- 1	4/2019
		-	STRE	EET ADDRESS, CITY, STATE, ZIP CO	DD	
NAME OF F	PROVIDER OR SUPPLIE	R		E NORTH B STREET		
HOMETO	OWN HOME HEAL	THCARE INC	GAS	S CITY, IN 46933		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFL	X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE PPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG			DATE
		flected the complexities of the		17-12-1(e) and Hometo		
		an ongoing program for		Healthcare policy B-100		
	quality improveme	ent for 1 of 1 agency.		Body and B-260 Perform	mance	
				Improvement. The Adm	inistrator	
	Findings include:			and Director of Nursing		
				meeting with the Gover		
		ent titled, "Quality assessment		to address the QAPI pro	•	
	-	nprovement", provided by the		develop areas that requ		
	director of nursing (DON), stated " Problem:			monitoring, areas that t		
		educate staff on Universal Precautions upon hire where		room for improvement i	n, areas	
				where we will be able to	o resolve	
	and yearly thereafter -educate client on Universal			identified problems, and	d to improve	
	Precautions upon admission and with SN assessments -document antibiotic usage and type of infection - monitor for possible transmission of			patient care.		
				The Administrator and I		
			Nursing will develop a C			
	-	iver - SN (skilled nurse) will		program that is approve	•	
	-	al doctor) with any possible		Governing Body and wi		
		rdered medication Goals:		with the Governing Bod	ly at least	
		from infection. Client will have		quarterly to ongoing mo	-	
		on therapy for illness. Client will		improvement of quality		
	have no adverse re	actions to medication"		The Administrator and I		
				Nursing have develope		
	-	y policy titled, "INFECTION		program that has been		
		" provided by the director of		by the Governing Body		
		10/23/19 at 10:20 AM stated, "		included problem areas		
		nagement team including the		control/universal precau		
		l Services have the authority		quality of care and limit	-	
		cation and analysis of the		occurrence of missed v		
		e of all infections and shall		reducing falls/injuries, a		
	· ·	ment a plan for surveillance,		ensuring compliance wi		
	-	ntrol of infection hazards		medication regime by p	-	
		shall be based on an		client with medication p		
	-	risk and high volume		is in layman's terms and	-	
		sed agency needs based on		understand. The DON,		1
		Employee Health; the agency		QA personnel will monit	tor charts	
		ties and procedures related to		to ensure compliance.	ill moniter	
	infection"	ntion and control of employee		The Governing Body wi		1
	milection"			the QAPI program to er	isure that	
				the needs of the client's	oro hain -	

Facility ID: 013349

49 If continuation sheet

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Page 23 of 38

HOMETOWN (X4) ID PREFIX TAG CO	SUMMARY (EACH DEFICIE	THCARE INC	:	STREET A	ET ADDRESS, CITY, STATE, ZIP COD		DATE SURVEY DMPLETED D/24/2019	
(X4) ID PREFIX TAG C	SUMMARY (EACH DEFICIE				ADDRESS, CITY, STATE, ZIP COD NORTH B STREET ITY, IN 46933	-		
PREFIX TAG CO	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE		040 0			T	
		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETIC DATE	
min in TH idu en of plu ag su in clu or pr min ac vir Ar an idu Pr in Pr an Ar idu Pr in Ar Ar Ar Ar Ar Ar Ar Ar Ar Ar	ONTROL SURV ON on 10/23/19 gency will estab onitoring and co fection or identi- ne Agency will i entifying all infe- nployee populati 'current control an to improve in- gency will perfor rveillanceClia fections are to b osely monitor ar injury resulting ofessional's clier onitored6. Th tions8. Data ill be reviewed a n undated docum id performance i entified, 'Probler oblem areas idea dicated on the de- revention and Co d Medications. n agency docum entified by the E inutes, stated, " ive [Employee E resident, and [En- ld Business; We pril 2017 sent ou softive remarks; ebruary 1, 2019;	OR LSC IDENTIFYING INFORMATION           VEILLANCE" provided by the at 10:20 AM stated, "POLICY; lish a continuous data llecting system to detect fy changes in infection trends mplement a process of ections in the client and / or ion and evaluate effectiveness measures or identify an action acidence of infections The m targeted infection control ent infections Employee e reported 5. The agency will ad investigate employee's illness from the health care nt care activities will closely e agency will identify follow - up related to identified infections and analyzed "           hent titled, "Quality assessment mprovement" indicated areas ms', 'Intervention' and 'Goals'. ntified by the agency as ocument: Client satisfaction, ontrol of infection, Falls / Injury           ent dated, "1 February 2018", DON as the Governing Body Meeting brought to order. We B] President, [Employee I], Vice mployee J], Secretary / Treasurer. got six new admissions in 2017; at 48 surveys received 13 back all New Business; Metting set for Budget; Budget has been b; Closing; meeting adjourned.		TAG	will improve. QAPI minutes w current and accurately depict status of programs at the tim the meeting. QAPI meetings be held at least quarterly, an any significant change in the program.	t the e of will d with	DATE	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/24/2019 15K118 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 302 E NORTH B STREET HOMETOWN HOME HEALTHCARE INC GAS CITY, IN 46933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE An agency document dated, "5 January 2019", identified by the DON as the Governing Body minutes, stated, " Meeting brought to order. We have [Employee B] President, [Employee I], Vice President, and [Employee J], Secretary / Treasurer. Old Business; Sent Out 57 Client surveys in August 2018 and received 13 back, with two wanting to discuss responses. Client had Bed Bugs February 2018 she was put on hold then her care plan expired. Eight new admissions. Client had Bed Bugs and had o put services on hold in October 2018. Client then ended up in the nursing home. New Business; In the near future, will be lookin for a Receptionist and Marketing personnel. Meeting set for January 24, 2020. Looking to Hire Nurses as well as CNA's. Budget has been approved for 2019...." The document failed to evidence the approval of QAPI program elements. An agency document dated, "Months: January, February, March 2018", titled, "Re: QAPI Meeting Quarterly Review" indicated, "Participating members present: [Employee B], Administrator... Members: [Employee, A], DON, [Employee I] Quality Assurance, [Employee J], Payroll, [Employee K], Billing, [Employee L] scheduler, [Employee M], scheduling coordinator / office manager. indicated, "... Coordinator [DON], concerning the programs stated goals for performance improvement, generated a quarterly report. We are evaluating client satisfaction, decrease in falls, and prevention/control of infection. We have reviewed and inserviced all employees on Universal Precautions SN's (skilled nurse) reviewed satisfactions, and we continue to monitor falls and implementation of fall precautions. Charts were QA'd (quality assurance) for many areas. These are ongoing CVFL11 Facility ID: 013349 Page 25 of 38 Event ID: State Form If continuation sheet

11/26/2019

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	r í	ILDING	NSTRUCTION 00	COM	x3) date survey completed 10/24/2019	
NAME OF	PROVIDER OR SUPPLII	ER			DDRESS, CITY, STATE, ZIP COD	-		
HOMET	OWN HOME HEAL	THCARE INC		302 E NORTH B STREET GAS CITY, IN 46933				
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	COMPLETIC	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	issues that will co	ntinue to be closely monitored						
	and tracked for qu	ality assurance and						
	performance impr	ovement. 1. Client satisfaction						
	· ·	all clients, each visit by SN ad						
		one conversations. There were						
	· · ·	ted this quarter that were						
		olved satisfactorily. 2.						
		ntrol of infection. RN reviewed						
		universal precautions inservice						
		Universal precautions were						
		h clients for control and						
		ction. We have had 7 orders						
	-	quarter with no adverse						
		No instances of caregivers being						
		lients noted. 3. Decreased falls						
		ea we are continuing to monitor						
		al is for all client's to remain free						
		ies in their homes. We have had						
	-	broken nose and finger, that was						
		policy. We have had _7_						
		quarter with injuries reported						
	-	g in ER (emergency room)						
		mission with head injury,						
		on" The document failed to						
		or aggregation of data collected						
	U	rove patient outcomes, failed to						
	-	c meeting date or members						
	present by signatu							
	present by signate							
	An unsigned und	ated document titled, "Re:						
		arterly Review Months:						
	· · ·	, March 2019" stated, " 2.						
		ntrol of infection. RN						
		reviewed and administered						
		ons inservice to all current staff.						
		ions were also reviewed with						
	_	and prevention of infections.						
		orders for antibiotics this						
	-	lverse reactions noted. No ivers being carriers between						
	instances of careg	ivers being carriers between						

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 10/24/2019	
	PROVIDER OR SUPPLIE		302 E	TADDRESS, CITY, STATE, ZIP NORTH B STREET CITY, IN 46933	COD		
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(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIO	
TAG	Clients noted"	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	May, June 2019", Quarterly Review/ members present: Members: [Employ Quality Assurance [Employee K], Bii [Employee M], sc manager. Coordin programs stated ge improvement, gen are evaluating clie and prevention/co reviewed and inse Universal Precauti reviewed satisfact monitor falls and i precautions. Char assurance) for man issues that will con and tracked for qu performance impri is addressed with upon frequent pho some concerns non addressed and rese Prevention and co and administered to to all current staff, also reviewed with prevention of infe- for antibiotics this reactions noted. N carriers between c in [sic] also an are this year. Our goa from falls or injur	ent dated, "Months: April, titled, "Re: QAPI Meeting "indicated, "Participating [Employee B], Administrator yee, A], DON, [Employee I] e, [Employee J], Payroll, lling, [Employee L] scheduler, heduling coordinator / office ator [DON], concerning the bals for performance erated a quarterly report. We int satisfaction, decrease in falls, introl of infection. We have rviced all employees on ions SN's (skilled nurse) ions, and we continue to implementation of fall ts were QA'd (quality my areas. These are ongoing ntinue to be closely monitored ality assurance and ovement. 1. Client satisfaction all clients, each visit by SN ad ne conversations. There were ted this quarter that were olved satisfactorily. 2. ntrol of infection. RN reviewed universal precautions inservice . Universal precautions were n clients for control and ction. We have had _8_ orders quarter with no adverse No instances of caregivers being lients noted. 3. Decreased falls ea we are continuing to monitor al is for all client's to remain free ies in their homes. We have had s this quarter with one fall					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	ì í	LDING	ISTRUCTION 00	CO	(X3) DATE SURVEY COMPLETED 10/24/2019	
	PROVIDER OR SUPPLIE			302 E NO	DDRESS, CITY, STATE, ZIP C ORTH B STREET 'Y, IN 46933	OD		
HOIVIET				GAS CH	f, in 40955			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE PPROPRIATE	COMPLETIC	
TAG		PR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		s to the head" The document						
		rending or aggregation of data						
		re or improve patient outcomes,						
	failed to evidence	a specific meeting date or						
	members present b	by signature.						
		ent dated, "Months: April,						
	-	titled, "Re: QAPI Meeting						
	· ·	' indicated, "Participating						
	-	[Employee B], Administrator						
		yee, A], DON, [Employee I]						
		e, [Employee J], Payroll,						
		ling, [Employee L] scheduler,						
	[Employee M], scl	heduling coordinator / office						
	-	ator [DON], concerning the						
	programs stated go	oals for performance						
		erated a quarterly report. We						
	-	nt satisfaction, decrease in falls,						
	-	ntrol of infection. We have						
		rviced all employees on						
		ons SN's (skilled nurse)						
		ions, and we continue to						
		mplementation of fall						
	•	ts were QA'd (quality						
		ny areas. These are ongoing						
		ntinue to be closely monitored						
	· ·	ality assurance and						
		ovement. 1. Client satisfaction						
		all clients, each visit by S ad						
		ne conversations. There were						
		ted this quarter that were						
		olved satisfactorily. 2.						
		ntrol of infection. RN reviewed						
		iniversal precautions inservice						
		Universal precautions were						
		a clients for control and						
	-	ction. We have had <u>3</u> orders						
		quarter with no adverse						
	reactions noted. N	lo instances of caregivers being						
	carriers between c	lients noted. 3. Decreased falls						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/24/2019 15K118 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 302 E NORTH B STREET HOMETOWN HOME HEALTHCARE INC GAS CITY, IN 46933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE in [sic] also an area we are continuing to monitor this year. Our goal is for all client's to remain free from falls or injuries in their homes. We have had 1 fall with injury, broken nose and finger, that was reported per (by) policy. We have had 18 reported falls this quarter with one fall resulting in staples to the head...." The document failed to indicate trending or aggregation of data collected to measure or improve patient outcomes, failed to evidence a specific meeting date or members present by signature. An unsigned, undated document titled, "Re: QAPI Meeting Quarterly Review Months: April, May, June 2019" stated, "... 2. Prevention and control of infection. RN (registered nurse) reviewed and administered universal precautions inservice to all current staff. Universal precautions were also reviewed with clients for control and prevention of infections. We have had 3 orders for antibiotics this quarter with no adverse reactions noted. No instances of caregivers being carriers between clients noted ...." During an interview on 10/23/19 at 2:19 PM the DON was asked if she trended and analyzed any of the data she collected for the QAPI program. She indicated she did not. During an interview on 10/24/19 at 1:07 PM, with the DON, she indicated she was not trending and analyzing data for staff and patient infections. When asked where the tracking for any staff infections were kept, she stated, "I'm not doing that." When asked if she had an infection control program that addressed surveillance, identification, prevention, control and investigation of staff and patient infections, she stated, "No." When asked about the information Event ID: CVFL11 Facility ID: 013349 Page 29 of 38 State Form If continuation sheet

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11/26/2019

	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(V2) MI		ONSTRUCTION	(X3) DATE S	B NO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER	ì í	LTIPLE CC	<u>00</u>	COMPLE	
AND FLAN	OF CORRECTION	15K118	B. WI		<u> </u>	10/24/2	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIE			302 E N	NORTH B STREET		
HOMET	OWN HOME HEAL	THCARE INC		GAS CI	TY, IN 46933		
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ngs that stated patients and					
		ated about universal					
	-	past two (2) quarters, she					
		mation on the meeting minutes					
		orrect. She stated she only					
	~	control and universal					
	^	the upon hire and annually,					
	when cold and flu	season begins.					
	During an intervie	w on 10/24/19 at 1:10 PM, with					
	e e	asked when the undated					
		Puality assessment and					
		ovement" located in the QAPI					
		nented and was it approved by					
	-	y? The DON stated, "I don't					
	know."	, ,					
N 0472	410 IAC 17-12-2	(a)					
		iance improvement					
Bldg. 00		) The home health agency					
		plement, maintain, and					
	evaluate a quality	assessment and					
	performance imp	rovement program. The					
	program must ref	flect the complexity of the					
	home health orga	anization and services					
	(including those s	services provided directly or					
	-	ent). The home health					
		e actions that result in					
	-	the home health agency's					
		oss the spectrum of care.					
	The home health						
		performance improvement					
	program must us	e objective measures.		70		(	11/00/001
	Decad on record	view and interview, the accord	N 04	12	The Administrator and Director	OT	11/22/201
		eview and interview, the agency			Nursing of Hometown Home		
		surable improvement in health safety, and quality of care and			Healthcare have reviewed		
	_	analyze, and track the quality			federal/state policy 410 IAC		
		rse patient events, failed to			17-12-2(a) and Hometown Hor Healthcare policy B 100 Cover		
		the QAPI [quality assurance			Healthcare policy B-100 Gover Body and B-260 Performance	ning	
	I nothing and tocus	and Qrin i [quanty assurance			Bouy and D-200 Fenomialice		

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE	E SURVEY
ND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER	A. BUILDING <b>00</b>			COMPLETED	
		15K118	B. WING	<u> </u>		10/24/2019	
	PROVIDER OR SUPPLIE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
HOMET	OWN HOME HEAL	THCARE INC		GAS CI	TY, IN 46933		
X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX		NCY MUST BE PRECEDED BY FULL	PF	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		ГAG	DEFICIENCY)		DATE
	· ·	mprovement] and PIP			Improvement. The Administra	ator	
	[performance impr	rovement program] programs on			and Director of Nursing had a	a	
	high risk, high vol	ume or problem-prone patient			meeting with the Governing E	Body	
	areas; failed to evi	dence tracking and analyzing of			to address the QAPI program	١,	
	adverse events and			develop areas that require clo			
	preventative action	ns; failed to implement and			monitoring, areas that there i		
	measure its succes			room for improvement in, are			
	a performance imp			where we will be able to reso			
	· ·	ified and failed to analyze			identified problems, and to in	-	
		ns to prevent the spread of			patient care.	ipi ove	
	further infections				The Administrator and Direct	or of	
		tor i or i ugeney.			Nursing will develop a QAPI		
	Findings include:					the	
	rindings include.				program that is approved by		
	A				Governing Body, and will me		
		nent titled, "Quality assessment			with the Governing Body at le		
	· ·	mprovement", provided by the			quarterly to ensure that goals		
		(DON), stated " Problem:			being met, areas of concern		
		ntrol of infection; Intervention:			being addressed, and that the	ere is	
		Jniversal Precautions upon hire			ongoing monitoring for		
		ter -educate client on Universal			improvement of quality of car		
	-	admission and with SN			The Administrator and Direct	or of	
	assessments -docu	ment antibiotic usage and type			Nursing have developed a Q	API	
	of infection - mon	itor for possible transmission of			program tht has been approv	ed by	
	infection via careg	iver - SN (skilled nurse) will			the Governing Body and inclu	uded	
	notify MD (medic	al doctor) with any possible			problem areas of infection		
	interactions with o	rdered medication Goals:			control/universal precautions	,	
	Client will be free	from infection. Client will have			quality of care and limiting th		
	effective medication	on therapy for illness. Client will			occurrence of missed visits,		
		actions to medication"			reducing fall/injuries, and ens	suring	
					compliance with medication	5	
	An undated, agence	y policy titled, "INFECTION			regime by providing client wit	h	
	-	" provided by the director of			medication profile that is in		
		10/23/19 at 10:20 AM stated, "			layman's terms and easy to		
		nagement team including the			understand. The DON, ADO	l and	
		al Services have the authority			QA personnel will audit chart		
		cation and analysis of the			ensure compliance.	5 10	
		-			!	itor	
		se of all infections and shall			The Governing Body will mor		
		ment a plan for surveillance,			the QAPI program to ensure		
	· ·	ntrol of infection hazards			the needs of the client's are t	•	
	activities related	. shall be based on an			addressed and that quality of	care	

Event ID: CVFL11 Facility ID: 013349

If continuation sheet Page 31 of 38

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		СОМ	(X3) DATE SURVEY COMPLETED 10/24/2019	
	PROVIDER OR SUPPLIE		302 E	FADDRESS, CITY, STATE, ZIP CO NORTH B STREET	DD		
HOMET	OWN HOME HEAL	THCARE INC	GAS	CITY, IN 46933			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETIC DATE	
	assessment high indicators assess data collection I shall develop polic surveillance, preve infection" An undated, agenc CONTROL SURV DON on 10/23/19 Agency will establ monitoring and co infection or identif The Agency will in identifying all infe employee populati of current control in plan to improve in agency will perfor surveillanceClic infections are to be closely monitor an or injury resulting professional's clien monitored6. The actions8. Data in will be reviewed a An undated docum and performance in identified, 'Problem Problem areas iden indicated on the do Prevention and Co and Medications. An agency docum-	a risk and high volume sed agency needs based on Employee Health; the agency cies and procedures related to ention and control of employee ey policy titled, "INFECTION /EILLANCE" provided by the at 10:20 AM stated, "POLICY; lish a continuous data llecting system to detect fy changes in infection trends mplement a process of ections in the client and / or on and evaluate effectiveness measures or identify an action cidence of infections The m targeted infection control ent infections Employee e reported 5. The agency will d investigate employee's illness from the health care at care activities will closely e agency will identify follow - up related to identified infections		will improve. QAPI minu current and accurately status of programs at th the meeting. QAPI mee be held at least quarter any significant change in program	depict the ne time of etings will ly, and with		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	X3) DATE SURVEY COMPLETED 10/24/2019		
NAME OF PROVIDER OR SUPPLIER HOMETOWN HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP COD 302 E NORTH B STREET GAS CITY, IN 46933				
(X4) ID PREFIX	SUMMARY	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP	ULD BE	(X5) COMPLETIO	
TAG	President, and [En Old Business; We April 2017 sent ou positive remarks; J February 1, 2019; approved for 2018 The document fail the QAPI program An agency docum identified by the E minutes, stated, "J have [Employee B President, and [En Old Business; Sen August 2018 and r wanting to discuss Bugs February 20 care plan expired. had Bed Bugs and October 2018. Cli home. New Busin lookin for a Recep personnel. Meetir Looking to Hire N has been approved failed to evidence elements. An agency docum February, March 2 Quarterly Review' members present: Members: [Emplo Quality Assurance [Employee K], Bil [Employee M], sci manager. indicated	R LSC IDENTIFYING INFORMATION         apployee J], Secretary / Treasurer.         got six new admissions in 2017;         tt 48 surveys received 13 back all         New Business; Metting set for         Budget; Budget has been         ; Closing; meeting adjourned.         ed to evidence the approval of         a elements.         ent dated, "5 January 2019",         DON as the Governing Body         Meeting brought to order. We         B] President, [Employee I], Vice         nployee J], Secretary / Treasurer.         t Out 57 Client surveys in         received 13 back, with two         responses. Client had Bed         18 she was put on hold then her         Eight new admissions. Client         had o put services on hold in         ient then ended up in the nursing         uess; In the near future, will be         tionist and Marketing         ug set for January 24, 2020.         urses as well as CNA's. Budget         I for 2019" The document         the approval of QAPI program         ent dated, "Months: January,         uols", titled, "Re: QAPI Meeting         ' indicated, "Participating         [Employee B], Administrator         yee, A], DON, [Employee I] <tr< th=""><th>TAG</th><th>DEFICIENCY)</th><th></th><th>DATE</th></tr<>	TAG	DEFICIENCY)		DATE	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/24/2019 15K118 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 302 E NORTH B STREET HOMETOWN HOME HEALTHCARE INC GAS CITY, IN 46933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE report. We are evaluating client satisfaction, decrease in falls, and prevention/control of infection. We have reviewed and inserviced all employees on Universal Precautions SN's (skilled nurse) reviewed satisfactions, and we continue to monitor falls and implementation of fall precautions. Charts were QA'd (quality assurance) for many areas. These are ongoing issues that will continue to be closely monitored and tracked for quality assurance and performance improvement. 1. Client satisfaction is addressed with all clients, each visit by SN ad upon frequent phone conversations. There were some concerns noted this quarter that were addressed and resolved satisfactorily. 2. Prevention and control of infection. RN reviewed and administered universal precautions inservice to all current staff. Universal precautions were also reviewed with clients for control and prevention of infection. We have had 7 orders for antibiotics this guarter with no adverse reactions noted. No instances of caregivers being carriers between clients noted. 3. Decreased falls in [sic] also an area we are continuing to monitor this year. Our goal is for all client's to remain free from falls or injuries in their homes. We have had 1 fall with injury, broken nose and finger, that was reported per (by) policy. We have had 7 reported falls this quarter with injuries reported with fall, resulting in ER (emergency room) evaluation and admission with head injury, increased confusion...." The document failed to indicate trending or aggregation of data collected to measure or improve patient outcomes, failed to evidence a specific meeting date or members present by signature. An unsigned, undated document titled, "Re: QAPI Meeting Quarterly Review Months: January, February, March 2019" stated, "... 2. CVFL11 Facility ID: 013349 Page 34 of 38 Event ID: State Form If continuation sheet

11/26/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/24/2019 15K118 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 302 E NORTH B STREET HOMETOWN HOME HEALTHCARE INC GAS CITY, IN 46933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Prevention and control of infection. RN (registered nurse) reviewed and administered universal precautions inservice to all current staff. Universal precautions were also reviewed with clients for control and prevention of infections. We have had 8 orders for antibiotics this quarter with no adverse reactions noted. No instances of caregivers being carriers between clients noted ...." An agency document dated, "Months: April, May, June 2019", titled, "Re: QAPI Meeting Quarterly Review" indicated, "Participating members present: [Employee B], Administrator... Members: [Employee, A], DON, [Employee I] Quality Assurance, [Employee J], Payroll, [Employee K], Billing, [Employee L] scheduler, [Employee M], scheduling coordinator / office manager. Coordinator [DON], concerning the programs stated goals for performance improvement, generated a quarterly report. We are evaluating client satisfaction, decrease in falls, and prevention/control of infection. We have reviewed and inserviced all employees on Universal Precautions SN's (skilled nurse) reviewed satisfactions, and we continue to monitor falls and implementation of fall precautions. Charts were QA'd (quality assurance) for many areas. These are ongoing issues that will continue to be closely monitored and tracked for quality assurance and performance improvement. 1. Client satisfaction is addressed with all clients, each visit by SN ad upon frequent phone conversations. There were some concerns noted this quarter that were addressed and resolved satisfactorily. 2. Prevention and control of infection. RN reviewed and administered universal precautions inservice to all current staff. Universal precautions were also reviewed with clients for control and CVFL11 Facility ID: 013349 Page 35 of 38 Event ID: State Form If continuation sheet

11/26/2019

AND PLAN OF CORRECTION IDENTIFI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118				(X3) DATE SURVEY COMPLETED 10/24/2019		
NAME OF	PROVIDER OR SUPPLI	ĒR	•	302 E N	DDRESS, CITY, STATE, ZIP	COD		
HOMET	OWN HOME HEAL	THCARE INC		GAS CI	TY, IN 46933			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	DRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION	SHOULD BE	COMPLETIC	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRI			DATE	
	prevention of infe	ction. We have had <u>8</u> orders						
	for antibiotics this	quarter with no adverse						
	reactions noted. N	No instances of caregivers being						
	carriers between c	lients noted. 3. Decreased falls						
	in [sic] also an ar	ea we are continuing to monitor						
		al is for all client's to remain free						
	5	ies in their homes. We have had						
		s this quarter with one fall						
	resulting in staple							
	failed to indicate t	rending or aggregation of data						
	collected to measu	ire or improve patient outcomes,						
	failed to evidence	a specific meeting date or						
	members present	by signature.						
	Quarterly Review members present: Members: [Emplo Quality Assurance [Employee K], Bi [Employee M], sc manager. Coordin programs stated ge improvement, gen are evaluating clie and prevention/co reviewed and inse Universal Precaut reviewed satisfact monitor falls and precautions. Char assurance) for man issues that will co and tracked for qu performance impr is addressed with upon frequent pho	titled, "Re: QAPI Meeting "indicated, "Participating [Employee B], Administrator yee, A], DON, [Employee I] e, [Employee J], Payroll, lling, [Employee L] scheduler, heduling coordinator / office ator [DON], concerning the bals for performance erated a quarterly report. We ent satisfaction, decrease in falls, ntrol of infection. We have rviced all employees on ions SN's (skilled nurse) ions, and we continue to implementation of fall ts were QA'd (quality ny areas. These are ongoing ntinue to be closely monitored ality assurance and ovement. 1. Client satisfaction all clients, each visit by S ad one conversations. There were tod this guarter thet were						
		ted this quarter that were blved satisfactorily. 2.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K118	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			CO	(X3) DATE SURVEY COMPLETED 10/24/2019	
			•	302 E N	ADDRESS, CITY, STATE, ZIP C NORTH B STREET	COD		
HOMETOW	/N HOME HEAL	THCARE INC		GAS CI	TY, IN 46933			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
I A A A A A A A A A A A A A A A A A A A	Prevention and co and administered in o all current staff ilso reviewed with prevention of infe- for antibiotics this eactions noted. It arriers between co in [sic] also an ar- his year. Our goa rom falls or injur- fall with injury, eported per (by) peported falls this taples to the head indicate trending of o measure or imp- widence a specifi- present by signature An unsigned, unda QAPI Meeting Qu May, June 2019" so control of infection eviewed and administervice to all cur- precautions were a control and preven- tad _3_ orders for diverse reactions aregivers being co "	ntrol of infection. RN reviewed universal precautions inservice . Universal precautions were in clients for control and ction. We have had _3_ orders quarter with no adverse No instances of caregivers being lients noted. 3. Decreased falls ea we are continuing to monitor il is for all client's to remain free ties in their homes. We have had broken nose and finger, that was policy. We have had _18_ quarter with one fall resulting in " The document failed to or aggregation of data collected rove patient outcomes, failed to c meeting date or members re. atted document titled, "Re: marterly Review Months: April, stated, " 2. Prevention and n. RN (registered nurse) inistered universal precautions rrent staff. Universal also reviewed with clients for nation of infections. We have antibiotics this quarter with no noted. No instances of arriers between clients noted						

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

NTERS FOI	R MEDICARE & MEDIC	AID SERVICES				ON	4B NO. 0938-039
STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         15K118		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 10/24/2019	
	PROVIDER OR SUPPLIEF			302 E N	ADDRESS, CITY, STATE, ZIP COD IORTH B STREET TY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CC PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE TAG DEFICIENCY)		BE	(X5) COMPLETION DATE
	infections were kep that." When asked program that address identification, preve investigation of staf stated, "No." When on the QAPI meetin staff were re-educat precautions for the indicated the inform for QAPI were inco provided infection of	ention, control and if and patient infections, she a sked about the information has that stated patients and ted about universal past two (2) quarters, she hation on the meeting minutes prrect. She stated she only control and universal e upon hire and annually,					