Printed: 06/07/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K025		B. WING		C <b>04/23/2021</b>	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
INDIVIDU	AL SUPPORT HOME I	HEALTH AGENCY		ECHWOOD A ETOWN, IN			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY  OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
G 000	INITIAL COMMENTS	6		G 000			
	re-licensure survey, a (2) complaints. This was a fully exter order. IN00347100 - Unsub						
	IN00314538 - Unsubstantiated Survey Dates: April 19-23, 2021						
	Facility number: 011160 Provider number: 15K025						
	Current census: 171						
	Skilled: 40 HHA only: 131						
		eflects State Findings ci IAC 17. Refer to the S tate Findings.					
G 528	Health, psychosocial, CFR(s): 484.55(c)(1)			G 528			
	The patient's current health, psychosocial, functional, and cognitive status; This Element is not met as evidenced by: Based on record review and interview, the registered nurse (RN) failed to ensure the comprehensive assessment contained all pertinent information regarding the patients' current health status for 2 of 8 active records reviewed (#1, 5).						
	The findings included	d:					
	An agency policy "comprehensive client"	dated 3/1/21 titled nt assessment," stated					
1 A D O D A T O D		D/CLIDDLIED DEDDECENTATIV	ISIO OLONIATURE		TITLE	(YE) DATE	

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

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

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		15K025		B. WING		04/	C <b>23/2021</b>	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	ΓE, ZIP CODE	•		
INDIVIDU	AL SUPPORT HOME	HEALTH AGENCY		ECHWOOD A ETOWN, IN				
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	'E ACTION SHOULD BE D TO THE APPROPRIATE		
G 528	"Purpose: To deter treatment and service and his/her changing comprehensive asse reflect the client's staminimum, the following current health with a assessment, psychologognitive status"  2. The clinical record on 4/19/21 and indicated "check INR [in ratio-blood test that reflect the anticoagulant means known as coumadin) results [to warfarin/completed on 3/18/2 diagnosis or docume INR blood tests to be 3. The clinical record on 4/21 and 4/23/202 care date of 9-28-20 plan of care for the completed on 3/18/2 diagnosis or docume INR blood tests to be 3. The clinical record on 4/21 and 4/23/202 care date of 9-28-20 plan of care for the completed on 3/18/2 diagnosis or docume INR blood tests to be 3. The clinical record on 4/21 and 4/23/202 care date of 9-28-20 plan of care for the complete of 5/14/2021, with order services.  Review of an OASIS assessment, dated 3 failed to evidence the aspart of vital sign a for care planning.  During an interview of the administrator and the administrator and the services and the services are planning.	mine the appropriate cases to meet client initial ray needs The essment must accurately atus, and must include and information: The clie completed head to toe social, functional, and dof patient #1 was revie ated a start of care date contained a plan of care and of 3/23/21-5/21/21 whaternational normalized monitors the effectivenes edication warfarin (also of years) Monday and calcumadin clinic]"  In the properties of the rationale of the rational of the rati	needs  / t a nt's  ewed e of e for nich ss of  I  ent for ewed t of ed a 6 to  , eight, asis	G 528				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K025		B. WING		C 04/23/2021	
NAME OF PROVIDER OR SUPPLIER STREET AL				RESS, CITY, STA		•	
INDIVIDU	AL SUPPORT HOME	HEALTH AGENCY		ECHWOOD A ETOWN, IN			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE	TION
G 528	#5's height and weig obtained and documassessment.  4. During an intervie alternate administraticomprehensive asse	ht should have been ented in the comprehen w on 4/22/21 at 9:20 Al	M, the	G 528			
G 530	CFR(s): 484.55(c)(2)  The patient's strength preferences, includin used to demonstrate toward achievement patient and the measiby the HHA; This Element is not Based on record reviregistered nurse (RN comprehensive assepatient's goals, and conformation to demonachievement of goals measurable outcome 2 of 8 active records  Findings include:  1. An agency policy "comprehensive client"The comprehensive accurately reflect and care preferences may be used to emotoward acheivement.	hs, goals, and care g information that may the patient's progress of the goals identified bearable outcomes identified by the additional of the same tas evidenced by: new and interview, the last of the same trace preferences, as we astrate progress toward is identified by the patients identified by the agent reviewed (#1, 4).	y the fied  Il as  It and acy for  als, that ress y the	G 530			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		15K025		B. WING			C 3/ <b>2021</b>	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
INDIVIDU	AL SUPPORT HOME H	HEALTH AGENCY		ECHWOOD A				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
G 530	2. The clinical record on 4/19/21 and indica 8/21/17. The record of the certification period listed diagnoses (but brain injury, quadriple and history of urinary). A recertification computed at 3/18/21 failed to goals, and care prefedemonstrate progress goals identified by the outcomes identified by the outcomes identified by 3. The clinical record on 4/20//2021, and in of 7-12-2019. The clir of care for the certifica 5/142021, with orders. Review of an OASIS/assessment, dated 3/to evidence the patier and care preferences basis for care plannin. During an interview of the administrator and reviewed the clinical reviewed when adopt record system at the record system at	of patient #1 was reviewed a start of care date contained a plan of care do of 3/23/21-5/21/21 who not limited to) tramauticegia, constipation, dyspletract infection.  The patient was assessment to evidence the patient's rences, information to be toward achievement of expatient, or measurable by the agency.  If of patient #4 was reviewed dicated a start of care of contained a start of care of contained and the patient was reviewed by the agency.  If of patient #4 was reviewed action period of 3/3 to be for skilled nursing served comprehensive (2/2021, for patient #4, int's strengths, weakness had been documented by the patient was a patie	of e for nich c hagia,  of e e e e e e e e e e e e e e e e e e	G 530				
G 536	preferences. A review of all current CFR(s): 484.55(c)(5)	t medications		G 536				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER			1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K025		B. WING		C <b>04/23/2021</b>
	OVIDER OR SUPPLIER AL SUPPORT HOME	HEALTH AGENCY	956 BE	ECHWOOD A	AVENUE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
G 536	using in order to ider effects and drug read drug therapy, signific drug interactions, du noncompliance with This Element is not Based on record revifailed to ensure the pmedications the patie #5) of 8 active record The findings included The clinical record of 4/21 and 4/23/2021, date of 9-28-2018. To f care for the certific 5/14/2021, with orde services.  Review of document request on 4/8/2021, "Other identifier of A, therapy for patient #8 milligrams/10 mL, SV injection) every 12 hoorder 3-29-2021 (end Review of the medication list, to independ on the product of the medication list, to independ on the product of the medication list, to independ on the product of the medication list, to independ on the product of the medication list, to independ on the product of the medication list, to independ on the product of the medication profile for medication profile for medication profile for the product of the pro	rations the patient is curnitify any potential adversations, including ineffect cant side effects, signific plicate drug therapy, and drug therapy.  met as evidenced by: iew and interview, the ablan of care documented ent was taking for 1 (Parads reviewed.  d::  f patient #5 was reviewed and indicated a start of the record contained a potential period of 3/16 to reside for skilled nursing  s obtained by fax, after from home health ager which provided infusions, evidenced Cefepime, WFI (sterile water for pours for 6 weeks, date of de-9-2021.)  ations on the plan of calcidication profile, failed to an antibiotic, had been	gency d all tient  ed on care olan  ncy on 1000  of	G 536		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K025		B. WING		04/2	C 2 <b>3/2021</b>	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STAT	TE, ZIP CODE			
INDIVIDU	AL SUPPORT HOME H	HEALTH AGENCY		ECHWOOD A ETOWN, IN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
G 536	duplicative drug thera medication profile evi taking approximately  On 4/23/2021 at 12:3 nursing supervisor be record and indicated added to the medication been checked for dru	apy. The agency's denced patient #5 was 13 medications.  O PM, the administrato the reviewed the clinical the Cefepime had not lion profile, plan of care g interactions with pati	r and I been e, or	G 536				
G 574	added to the medication profile, plan of care, or been checked for drug interactions with patient #5's other multiple medications.  Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi)  The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education;		G 574					

directives; and

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15K025			B. WING		04/2	C <b>04/23/2021</b>		
NAME OF DR	OVIDER OR SUPPLIER		STREET ADDE	<b> </b> RESS, CITY, STA	TE ZIP CODE			
	AL SUPPORT HOME H	HEALTH AGENCY		ECHWOOD A				
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	allowed practitioner methods. This Element is not in Based on record reviet failed to ensure the plant medications the particular durable medical equipment of 2 of 8 records reviewed (#15). Findings include:  1. An agency policy of Care," Policy # C-580 plan of care signed by required for each clied be completed in full to	ew and interview, the aglan of care (POC) includation was taking and altoment (DME) and supplewed for 2 of 8 active, 5).  dated 3/1/21 titled "Plare of Stated, "An individuation of care in the ca	gency ded I lies n of alized hall					
	on 4/19/21 and indica 8/21/17. The record of the certification period listed DME as (but no hospital bed, hoyer lift shower chair, wheelcd During a home visit of 8:00 AM with patient; E was observed provide visit, a bedside to and a foam overlay for were observed. The blisted on the plan of comparing an interview of	bservation on 4/20/21 a #1, home health aide (h iding personal care. Do able, humidifier, TED ho or the bed observed items failed to are.  n 4/22/21 at 4:02 PM, t ager stated all DME sh	of e for nich , at HHA) uring ose, o be					
	3. The clinical record	of patient #5 was revie	ewed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
,	0011112011011						C	
		15K025		B. WING		04/2	3/2021	
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
INDIVIDU	AL SUPPORT HOME I	HEALTH AGENCY		ECHWOOD A				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 574	care date of 9-28-201 plan of care for the ce 5/14/2021, with order services.  Review of documents request on 4/8/2021, "Other identifier of A," therapy for patient #5 milligrams/10 mL (mill for injection) every 12 order 3-29-2021 (end Review of the plan of antibiotic for infusion, documented on the p #5's medication list.  On 4/23/2021 at 12:3 nursing supervisor borecord and verified th added to the plan of for patient #5.  17-13-1(a)(1)(D)(ix) Infection Prevention CFR(s): 484.70(a)	21, and indicated a star 18. The record contain ertification period of 3/1 is for skilled nursing a obtained by fax, after from home health age! "which provided infusion, evidenced Cefepime, Illiliter), SWFI (sterile was 2 hours for 6 weeks, day 6-9-2021.)  If care failed to evidence a Cefepime, had been plan of care to update poth reviewed the clinical the Cefepime had not be care, as it should have	ed a 16 to ncy on 1000 ater te of atient or and il een been,	G 574				
	practice, including the precautions, to preve infections and common This Standard is not Based on observation failed to ensure all stapprecautions and infections.	e use of standard int the transmission of unicable diseases. met as evidenced by: n and interview, the ago	ency r 1 of					

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		15K025		B. WING		04/	C <b>23/2021</b>
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	TE, ZIP CODE		
INDIVIDU	AL SUPPORT HOME	HEALTH AGENCY		ECHWOOD A			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 682	Findings include:  During a home visit 8:00 AM with patien HHA E was observe HHA E washed hand different times for 5 seconds, and 5 seconds, and 5 seconds anitizer was utilized After hand sanitizer rubbed hands togeth hands to dry prior to failed to wash hands vigorously together.	observation on 4/20/21 at #1 (start of care 8/21/12 d providing personal cards throughout the visit at seconds, 8 seconds, 3 onds. Additionally, hand at least once during the was applied to hands, Her briefly and then shoot donning gloves. HHA is for 20 seconds or rub huntil the hands were dry	7), re. t  e visit. HHA E bk anands	G 682			

M77U11