STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH ANGELS LLC	**117 N MAIN ST PO BOX 283 , WINCHESTER, Indiana, 47394**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR S 484.22. Survey Dates: October 19, 20, 21, 22, 25; 2021 Facility Number: 012094 Provider ID: 157610 Active Census: 72 At this Emergency Preparedness survey, Home Health Angels was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR S 484.22	E0000		
E0037	EP Training Program CFR(s): 403.748(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E0037		

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

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

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E0037	Continued from page 1 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E0037		

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E0037	Continued from page 2 (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually.	E0037		

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E0037	Continued from page 3 (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training.	E0037		

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E0037	Continued from page 4 (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to maintain an Emergency Preparedness Plan (EPP) training program which trained staff on the plan every 2 years and kept documentation of the training, which had the potential to affect all patients and employees. 1. An undated agency policy titled “Emergency Care Policy” indicated but was not limited to “… Staff will be informed of emergency procedures during orientation, with any changes or updates to the process, and reviewed annually … Emergency Plan … All staff shall receive emergency preparedness training appropriate for their position at hire, with any updates and changes, and on a yearly basis ….” 2. The agency’s Emergency Preparedness binder was reviewed on 10/25/21. The binder failed to evidence documentation of emergency preparedness training performed after 2017. 3. The personnel file of the Administrator was reviewed on 10/25/21. The file failed to evidence documentation of emergency preparedness training performed after 2017. 4. The personnel file of the Clinical Manager was reviewed on 10/25/21. The file failed to evidence documentation of emergency preparedness training performed after 2017.	E0037		

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E0037	Continued from page 5 5. The personnel file of the Alternate Administrator was reviewed on 10/25/21. The file failed to evidence documentation of emergency preparedness training performed after 2017. 6. The personnel file of Physical Therapy Assistant (PTA #1) was reviewed on 10/25/21. The file failed to evidence documentation of emergency preparedness training performed after 2017. 7. The personnel file of Social Worker (MSW #1) was reviewed on 10/25/21. The file failed to evidence documentation of emergency preparedness training performed after 2017. 8. An interview was conducted on 10/25/21 at 5:22 PM with the Administrator, Clinical Manager, Alternate Administrator, and Administrative Assistant #1. During the interview, the Administrator confirmed emergency preparedness training should be conducted at least every two years. The Administrator also confirmed the agency had not conducted emergency preparedness training of all staff since 2017.	E0037		
G0000	INITIAL COMMENTS This was a Federal recertification, State re-licensure survey, and COVID-19 focused infection control survey of a Home Health Agency. The survey was announced as fully extended on 10/25/21 at 4:07 PM. Survey Dates: October 19, 20, 21, 22, 25; 2021 Facility Number: 012094 Provider ID: 157610 Unduplicated Admissions for Past 12 Months: 194 Active Census: 72 These deficiencies reflect State Findings cited in accordance with 410 IAC 17.	G0000		
G0550	At discharge CFR(s): 484.55(d)(3) At discharge. This ELEMENT is NOT MET as evidenced by:	G0550		

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G0550	Continued from page 6 Based on record review and interview, the home health agency failed to ensure the discharge summary included the patient's progress towards their goals for 2 of 2 discharge records reviewed (#6, 7). 1. An undated agency policy titled "Discharge Summary" indicated but was not limited to "… Special Instructions: 1. When a patient is discharged from the agency, the supervising professional shall complete a Discharge Summary form … 3. The Registered Nurse [RN]/Therapist will assure that the treatment goals and patient outcomes have been met …." 2. The clinical record of Patient #6 was reviewed on 10/22/21 and indicated a discharge date of 6/4/21 for the reason of "patient/family request. Patient transferring to hospice care." The record included a Discharge Assessment completed on 6/4/21 by RN #2. The discharge summary failed to evidence Patient #6's progress towards their goals. 3. The clinical record of Patient #7 was reviewed on 10/22/21 and indicated a discharge date of 8/6/21 for the reason of "patient transferring to hospice care." The record included a Discharge Assessment completed on 8/6/21 by RN #2. The discharge summary failed to evidence Patient #6's progress towards their goals. 4. An interview was conducted on 10/22/21 at 3:05 PM with the Administrator, Clinical Manager, Alternate Administrator, and Administrative Assistant #1. During the interview, the Clinical Manager confirmed the discharge summary should include the patient's progress towards their goals.	G0550		
G0564	Discharge or Transfer Summary Content CFR(s): 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care.	G0564		

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G0564	Continued from page 7 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure a discharge summary was sent to the receiving agency for 2 of 2 discharge records of patients transferred to another agency (#6, 7). 1. An undated agency policy titled “Discharge Summary” indicated but was not limited to “… Special Instructions: 1. When a patient is discharged from the agency, the supervising professional shall complete a Discharge Summary form … 4. If the patient is being referred to another agency or facility, a Transfer Summary form shall also be completed ….” 2. The clinical record of Patient #6 was reviewed on 10/22/21 and indicated a discharge date of 6/4/21 for the reason of “patient/family request. Patient transferring to hospice care.” The record included a Discharge Assessment completed on 6/4/21 by RN #2. The record failed to evidence the discharge summary was sent to the receiving hospice agency. 3. The clinical record of Patient #7 was reviewed on 10/22/21 and indicated a discharge date of 8/6/21 for the reason of “patient transferring to hospice care.” The record included a Discharge Assessment completed on 8/6/21 by RN #2. The record failed to evidence the discharge summary was sent to the receiving hospice agency. 4. An interview was conducted on 10/22/21 at 3:05 PM with the Administrator, Clinical Manager, Alternate Administrator, and Administrative Assistant #1. During the interview, the Clinical Manager confirmed the agency did not send a discharge or transfer summary to the receiving agency. The Clinical Manager also confirmed a “verbal communication … report” was given to the receiving agency when a patient was discharged or transferred to another agency.	G0564		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses;	G0574		

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G0574	Continued from page 8 (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; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the plan of care (POC) included the patient's mental, psychosocial, and cognitive status; all supplies and equipment required; duration of visits to be made; activities permitted, all medications and treatments, all safety measures to protect against injury; necessary interventions related to the patient's risks for ED visits and hospital readmission; patient specific, detailed, and measurable goals; advance directives	G0574		

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G0574	Continued from page 9 information, and any additional items, for 5 of 5 active records reviewed (#1, 2, 3, 4, 5). 1. An undated agency policy titled “Plan of Care” indicated but was not limited to “… Special Instructions … 2. The individualized plan of care must include the following: … The patient’s mental, psychosocial, and cognitive skills … The types of … supplies, and equipment required … duration of visits to be made … Activities Permitted … All medications and treatments … Safety measures to protect against injury … 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 … Patient and caregiver education and training to facilitate timely discharge … measurable outcomes and goals … Information related to any advanced directives … Any additional items ….” 2. Chippewa Valley Technical College (no date). Nursing Skills. Retrieved 10/27/21 from https://wtcs.pressbooks.pub/nursingskills/. “… Enteral Tube Management … nurses perform additional interventions to prevent aspiration. The American Association of Critical Care Nurses recommends the following guidelines to reduce the risk for aspiration: … Assess feeding tube placement … Assess for gastrointestinal intolerance … Measurement of gastric residual volume (GRV) [measurement of enteral feeding remaining in stomach] is performed by using a 60-mL syringe to aspirate stomach contents through the tube. It has traditionally been used to assess aspiration risk ….” 3. The clinical record of Patient #1 was reviewed on 10/20/2021 and indicated a start of care date of 9/14/21 with patient diagnoses including but not limited to presence of a G-tube (medical tube inserted into the stomach to assist with nutrition), adult failure to thrive, dysphagia (difficulty swallowing), and urinary tract infections. The record included a plan of care for the certification period 9/14/21 – 11/12/21. The POC’s service orders indicated the patient was to receive skilled nursing visits, 1 visit per week for 9 weeks and physical therapy (PT) and occupational therapy (OT) were to evaluate and treat. The record included an update to the plan of care, dated 9/22/21, which indicated the patient was to receive physical therapy services, 1 visit per week for 1 week then 2 visits per week	G0574		

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G0574	Continued from page 10 for 4 weeks. The plan of care failed to evidence the duration of visits to be provided. A home visit observation was conducted on 10/19/21at 1:27 PM with Patient #1 and Registered Nurse (RN) #1. During the visit, RN #1 confirmed Patient #1 had severe depression and Family Member #1 confirmed the patient still exhibited depression symptoms. Family Member #1 also confirmed Patient #1 was recently hospitalized for an “almost fall,” but the patient did not actually fall because the family member caught him prior to the patient hitting the floor. Patient #1 was observed with a G-tube present in his left upper abdomen, and RN #1 and Family Member #1 discussed the patient’s orders for enteral (administered directly into the stomach) nutrition administration. A pole, pump for enteral nutrition administration, and enteral administration tubing was observed to be present in the patient’s home. The POC failed to evidence the patient’s depression within the “Mental Status” section, failed to evidence the patient’s increased risk for falls within the “Safety Measures” section, failed to evidence the IV pole, feeding pump, and feeding tubing within the “DME [Durable Medical Equipment] and Supplies” section, and failed to evidence orders for frequency of assessing and call parameters for gastric residual volume. The POC included a section titled “Patient risk for Hospital and ER,” which evidenced the patient had multiple risk factors for hospitalization and ER visits. The section indicated but was not limited to “… Risk for hospitalization added to POC with appropriate interventions: Yes.” The POC failed to evidence the specific interventions the agency was to enact to reduce the patient’s risk factors for hospitalization and ER visits. The POC included a section titled “Goals/Rehabilitation Potential/Discharge Plans,” which indicated but was not limited to “… Goals: … Caregiver/Patient will be able to do G-tube feedings, flushes, and care. Patient will know [signs and symptoms] to report to MD ….” The POC failed to evidence patient-specific, detailed, and measurable goals. The POC included a section titled “Advance Directives” which was left blank. The POC failed to evidence the presence or absence of any advance directives.	G0574		

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G0574	Continued from page 11 4. The clinical record of Patient #2 was reviewed on 10/20/21 and indicated a start of care date of 7/15/21 with patient diagnoses including but not limited to myelodysplastic syndrome (group of blood cell production disorders), high blood pressure, and generalized muscle weakness. The record included a plan of care for the certification period 9/13/21 – 11/11/21 and a recertification comprehensive assessment completed on 9/10/21 by RN #1. The assessment indicated but was not limited to "… 60 Day Summary: Patient is alert and oriented with episodes of forgetfulness …." The POC failed to evidence the patient's forgetfulness within the "Mental Status" section. The POC's service orders indicated the patient was to receive skilled nursing visits, 1 visit per week for 9 weeks, and physical therapy and occupational therapy were to evaluate and treat the patient. The record included an update to the plan of care, dated 9/13/21, which indicated the patient was to receive PT services, 2 visits per week for 4 weeks, and OT services, 2 visits per week for 3 weeks. A second update to the POC, dated 9/30/21, indicated the patient was to continue to receive OT services, 2 visits per week for 3 weeks. A third update to the POC, dated 10/9/21, indicated the patient was to continue to receive PT services, 2 visits per week for 4 weeks. The plan of care failed to evidence the duration of visits to be provided. The POC's medication list indicated the patient was to receive Oxygen, 2 liters per minute at bedtime via "inhalation." The POC failed to evidence the specific route of administration for the oxygen (nasal cannula, mask, etc). The POC included a section titled "Patient risk for Hospital and ER," which evidenced the patient had multiple risk factors for hospitalization and ER visits. The section indicated but was not limited to "… Risk for hospitalization added to POC with appropriate interventions: Yes." The POC failed to evidence the specific interventions the agency was to enact to reduce the patient's risk factors for hospitalization and ER visits. The POC included a section titled "Goals/Rehabilitation Potential/Discharge Plans" which indicated but was not limited to "… Patient will safely perform ADLs and light IADLs with stable vital signs, with reduce[d] shortness of breath at modified independent level …." The POC	G0574		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0574	Continued from page 12 failed to evidence all goals were patient specific and measurable. The POC included a section titled “Advance Directives” which was left blank. The POC failed to evidence the presence or absence of any advance directives. 5. The clinical record of Patient #3 was reviewed on 10/20/21 and indicated a start of care date of 2/26/18 with patient diagnoses including but not limited to multiple sclerosis, hyperglycemia [high blood sugar], and urine retention. The record included a plan of care for the recertification period 10/8/21 – 12/6/21. A home visit observation was conducted on 10/20/21 at 9:55 AM with Patient #3 (start of care 2/26/18) and Home Health Aide (HHA) #1. During the visit, Family Member #2 confirmed the patient was being treated for depression and the patient had a Hoyer lift however the patient did not use this equipment due to inability to maneuver it and the patient being “scared” of the lift. Family Member #2 also confirmed the patient was bed bound other than leaving the home for doctor appointments, and the family member would transfer the patient from the bed to the wheelchair by himself. During the visit urostomy supplies, a hospital bed, and IV infusion supplies were observed within the home. The POC failed to evidence the patient’s depression within the “Mental Status” section, failed to evidence all equipment and supplies within the “DME and Supplies” section, and failed to evidence a more detailed and patient-specific “Activities Permitted” section. The POC included service orders for 3 skilled nursing visits “as needed” and home health aide (HHA) visits, 1 visit per week for 1 week, 5 visits per week for 8 weeks, then 1 visits per week for 1 week. The POC also included the HHA service orders for 4 visits per week for “4 hours a day. Hours may fluctuate due to Dr. appointments.” The POC failed to evidence clear orders for HHA services. The POC included the medication orders for acetaminophen-hydrocodone (Norco, opioid medication given to treat pain) 325 milligrams (mg)-5 mg twice a day “PRN” (as needed) by mouth; nystatin (given to treat fungal infections) 100,000 units/gram twice a day PRN on the skin; and Solumedrol (antibiotic given to treat	G0574		

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G0574	Continued from page 13 bacterial infections) “1 [gram] monthly IV.” The POC failed to evidence indications for administration for as needed medications and failed to evidence specific administration directions (administration rate, length of administration, etc). The POC included a section titled “Patient risk for Hospital and ER,” which evidenced the patient had multiple risk factors for hospitalization and ER visits. The section indicated but was not limited to “… Risk for hospitalization added to POC with appropriate interventions: Yes.” The POC failed to evidence the specific interventions the agency was to enact to reduce the patient’s risk factors for hospitalization and ER visits. The POC included a section titled “Goals/Rehabilitation Potential/Discharge Plans” which indicated but was not limited to “Pt [Patient] to remain clean, neat and odor free t/o [throughout] this cert period. Pt safety, nutrition, hydration, needs will be met t/o this cert period.” The POC failed to evidence patient-specific, detailed, and measurable goals. The POC included a section titled “Advance Directives” which was left blank. The POC failed to evidence the presence or absence of any advance directives. 6. The clinical record of Patient #4 was reviewed on 10/21/21 and indicated a start of care date 10/8/21 with patient diagnoses including but not limited to right hip fracture, COVID-19, pressure ulcers, cognitive communication deficit, and Type 2 Diabetes. The record included an initial plan of care for the certification period 10/8/21 – 12/6/21. The POC included service orders for skilled nursing, 1 visit per week for 1 week, 2 visits per week for 2 weeks, 1 visit per week for 6 weeks, and 1 visit per week for 1 week; physical therapy to evaluate and treat, and occupational therapy to evaluate and treat. The POC was updated on 10/12/21 with PT service visit orders for 1 visit per week for 1 week, 2 visits per week for 3 weeks. The POC failed to evidence the duration of visits to be conducted. The POC included a section titled “Patient risk for Hospital and ER,” which evidenced the patient had multiple risk factors for hospitalization and ER visits. The section indicated but was not limited to “… Risk for hospitalization added to	G0574		

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G0574	Continued from page 14 POC with appropriate interventions: Yes." The POC failed to evidence the specific interventions the agency was to enact to reduce the patient's risk factors for hospitalization and ER visits. The POC included a section titled "Advance Directives" which was left blank. The POC failed to evidence the presence or absence of any advance directives. 7. The clinical record of Patient #5 was reviewed on 10/21/21 and indicated a start of care 10/8/21 with the patient diagnoses including but not limited to left knee replacement, left knee osteoarthritis, and high blood pressure. The record included an initial plan of care for the certification period 10/8/21 – 12/6/21. The POC included service orders for skilled nursing for 1 visit per week for 5 weeks and physical therapy to evaluate and treat. The POC was updated on 10/11/21 with PT service orders for 3 visits per week for 1 week then 2 visits per week for 2 weeks. The POC included a section titled "Patient risk for Hospital and ER," which evidenced the patient had multiple risk factors for hospitalization and ER visits. The section indicated but was not limited to "… Risk for hospitalization added to POC with appropriate interventions: Yes." The POC failed to evidence the specific interventions the agency was to enact to reduce the patient's risk factors for hospitalization and ER visits. The POC included a section titled "Goals/Rehabilitation Potential/Discharge Plans" which indicated but was not limited to "… PT/INR [blood test used to check the time it takes for a patient's blood to clot] will be in therapeutic range t/o this cert period. Left knee incision will show signs of healing t/o this cert period." The POC failed to evidence patient specific, detailed, and measurable goals. The POC included a section titled "Advance Directives" which was left blank. The POC failed to evidence the presence or absence of any advance directives. 8. An interview was conducted on 10/22/21 at 3:05 PM with the Administrator, Clinical Manager, Alternate Administrator, and Administrative Assistant #1. During the interview, the Clinical Manager confirmed the plan of care should include	G0574		

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G0574	Continued from page 15 supplies and equipment required and advance directive information. The Administrator confirmed the plan of care should include the patient's mental, psychosocial, and cognitive status; duration of visits to be made, all medications and treatments, safety measures to protect against injury, interventions for the patient's risk factors for hospitalization and ED visits, and patient-specific and measurable goals. 17-13-1(a)(1)(C)(i, ii, iii, vii, ix, x, xiii)	G0574		
G0614	Visit schedule CFR(s): 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to provide the patient with a written schedule of visits for 3 of 3 home visit observations (#1, 2, 3). 1. An undated agency job description titled "Administrator Job Description" indicated but was not limited to "… 4. Develops policies and procedures to ensure compliance with federal and state laws and regulations … Client Care Duties … 7. Uphold all applicable state regulations and guidelines as set forth in Indiana Administrative Code and by the Indiana State Department of Health." 2. A home visit observation was conducted on 10/19/21 at 1:27 PM with Patient #1 (start of care 9/14/21) and Registered Nurse (RN) #1. During the visit, the patient's home health agency binder was observed and reviewed. The home binder failed to evidence a written schedule of visits was provided to the patient. An interview of Family Member #1 was conducted on 10/19/21 at 1:55 PM. During the visit, Family Member #1 confirmed the agency did not provide a written schedule of visits. 3. A home visit observation was conducted on 10/19/21 at 2:32 PM with Patient #2 (start of care 7/15/21) and Certified Occupation Therapist	G0614		

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G0614	Continued from page 16 Assistant (COTA) #1. During the visit, the patient's home health agency binder was observed and reviewed. The home binder failed to evidence a written schedule of visits was provided to the patient. A home visit observation was conducted on 10/20/21 at 9:55 AM with Patient #3 (start of care 2/26/18) and Home Health Aide (HHA) #1. During the visit, the patient's home health agency binder was observed and reviewed. The home binder failed to evidence a written schedule of visits was provided to the patient. 4. An interview was conducted on 10/20/21 at 1:30 PM with the Administrator, Clinical Manager, and Administrative Assistant #1. During the interview, the Administrator confirmed the agency did not provide a written copy of a visit schedule to all patients. The Administrator also indicated the home binder included blank calendar pages in case the patients "wanted" to fill them out.	G0614		
G0618	Treatments and therapy services CFR(s): 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to provide the patient with a written plan of care (POC) for 3 of 3 home visit observations (#1, 2, 3). 1. An undated agency job description titled "Administrator Job Description" indicated but was not limited to "… 4. Develops policies and procedures to ensure compliance with federal and state laws and regulations … Client Care Duties … 7. Uphold all applicable state regulations and guidelines as set forth in Indiana Administrative Code and by the Indiana State Department of Health." 2. A home visit observation was conducted on 10/19/21 at 1:27 PM with Patient #1 (start of care 9/14/21) and Registered Nurse (RN) #1. During the visit, the patient's home health agency binder was observed and reviewed. The home binder failed to	G0618		

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G0618	Continued from page 17 evidence the patient's plan of care. 3. A home visit observation was conducted on 10/19/21 at 2:32 PM with Patient #2 (start of care 7/15/21) and Certified Occupation Therapist Assistant (COTA) #1. During the visit, the patient's home health agency binder was observed and reviewed. The home binder failed to evidence the patient's plan of care. 4. A home visit observation was conducted on 10/20/21 at 9:55 AM with Patient #3 (start of care 2/26/18) and Home Health Aide (HHA) #1. During the visit, the patient's home health agency binder was observed and reviewed. The home binder failed to evidence the patient's plan of care. 5. An interview was conducted on 10/20/21 at 1:30 PM with the Administrator, Clinical Manager, and Administrative Assistant #1. During the interview, the Administrator confirmed the agency did not provide a written copy of the plan of care to the patient.	G0618		
G0622	Name/contact information of clinical manager CFR(s): 484.60(e)(5) Name and contact information of the HHA clinical manager. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to provide the clinical manager's name and contact information in writing to patients for 3 of 3 home visit observations (#1, 2, 3). 1. An undated agency job description titled "Administrator Job Description" indicated but was not limited to "… 4. Develops policies and procedures to ensure compliance with federal and state laws and regulations … Client Care Duties … 7. Uphold all applicable state regulations and guidelines as set forth in Indiana Administrative Code and by the Indiana State Department of Health." 2. An agency sample home binder was reviewed on 10/19/21 at 11:40 AM. The sample home binder failed to evidence the name and contact information for the clinical manager.	G0622		

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G0622	Continued from page 18 3. A home visit observation was conducted on 10/19/21 at 1:27 PM with Patient #1 (start of care 9/14/21) and Registered Nurse (RN) #1. During the visit, the patient's home health agency binder was observed and reviewed. The home binder failed to evidence the clinical manager's name and contact information. 4. A home visit observation was conducted on 10/19/21 at 2:32 PM with Patient #2 (start of care 7/15/21) and Certified Occupation Therapist Assistant (COTA) #1. During the visit, the patient's home health agency binder was observed and reviewed. The home binder failed to evidence the clinical manager's name and contact information. 5. A home visit observation was conducted on 10/20/21 at 9:55 AM with Patient #3 (start of care 2/26/18) and Home Health Aide (HHA) #1. During the visit, the patient's home health agency binder was observed and reviewed. The home binder failed to evidence the clinical manager's name and contact information. 6. An interview was conducted on 10/20/21 at 1:30 PM with the Administrator, Clinical Manager, and Administrative Assistant #1. During the interview, the Administrator confirmed the home binder did not include the clinical manager's name and contact information.	G0622		
G0682	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure all staff followed standard precautions and agency infection control policies and procedures related to hand hygiene and bag technique for 3 of 3 home visit observations (#1, 2, 3). 1. An undated agency policy titled "Handwashing/Hand Hygiene" indicated but was not	G0682		

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G0682	Continued from page 19 limited to "… Special Instructions: … Indications for hand washing and hand antisepsis: … d. Between tasks on the same patient … f. After removing gloves … Hand Hygiene Technique. 1. When decontaminating hands with an alcohol based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry …." 2. The Association for Biosafety and Biosecurity (5/4/2020). "COVID-19 FAQs PPE Use." Retrieved 10/19/21 from www.absa.org. "… 1. Can disposable gloves be reused? … Per the OSHA Bloodborne Pathogen Standard, disposable gloves cannot be reused … Gloves should be changed frequently during the day, even if not visibly contaminated … 2. Can disposable gloves be disinfected safely? Chemicals like alcohol (hand sanitizer) … can affect the porosity of gloves, causing them to become more porous and/or sticky … CDC does not recommend disinfection of disposable medical gloves as standard practice. This practice is inconsistent with general disposable glove usage, but, in times of extreme disposable medical glove shortages, the option may need to be considered …." 3. McGoldrick (3/2009). "Cleaning and Disinfection of Patient Care Equipment used in the Home Setting." Retrieved 11/5/21 from www.cdss.ca.gov " … Disinfection of Patient Care Equipment … vital sign equipment and supplies be cleaned with a low- or intermediate-level disinfectant in the home after use and prior to placing the equipment back in the nursing back for use on another patient … Disinfectant Contact Time. Contact time is the amount of time that the item or surface is to be kept 'wet' with the disinfectant up through complete drying of the disinfectant on the surface … Most EPA-registered hospital disinfectants have a label contact time of 10 minutes … staff member must follow the safety precautions and use directions on the labeling of each registered product. If they do not follow the specified … contact time … the practice is considered a misuse of the product …." 4. A home visit observation was conducted on 10/19/21 at 1:27 PM with Patient #1 (start of care 9/14/21) and Registered Nurse (RN) #1. During the visit, RN #1 wore the same pair of gloves through the entire visit, and applied alcohol based hand sanitizer (ABHS) directly on to the gloves five separate instances. RN #1 also removed her cell	G0682		

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G0682	Continued from page 20 phone from her shirt pocket during the visit, performed a calculation on it, then placed the phone into the nursing bag. The nurse failed to perform hand hygiene according to agency procedure and best practice, and failed to clean used items prior to placing them back into the nursing bag. 5. A home visit observation was conducted on 10/19/21 at 2:32 PM with Patient #2 (start of care 7/15/21) and Certified Occupation Therapist Assistant (COTA) #1. During the visit, COTA #1 obtained the patient's vital signs with a reusable thermometer, blood pressure monitor, and oxygen saturation probe, wiped the vital sign equipment with alcohol wipes, then placed the equipment immediately back into her bag. While wiping the equipment, the occupational therapy assistant was observed placing the used wipes on a clean drape. At the end of the visit, COTA #1 failed to perform hand hygiene after removing her gloves. 6. A home visit observation was conducted on 10/20/21 at 9:55 AM with Patient #3 (start of care 2/26/18) and Home Health Aide (HHA) #1. During the visit, HHA #1 waved her hands in the air after applying ABHS. The aide also failed to remove her gloves and perform hand hygiene after emptying the patient's suprapubic catheter. 7. An interview was conducted on 10/20/21 at 1:30 PM with the Administrator, Clinical Manager, and Administrative Assistant #1. During the interview, the Clinical Manager confirmed staff should wipe equipment and allow the alcohol to dry according to manufacturer's instructions prior to returning the equipment to the nursing bag, should not wave hands in the air when performing hand hygiene with ABHS, and should remove gloves and perform hand hygiene after handling a urinary catheter and urine. The Administrator confirmed the agency did not have any current shortages of gloves or other personal protective equipment. 17-12-1(m)	G0682		
G0706	Interdisciplinary assessment of the patient CFR(s): 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; This ELEMENT is NOT MET as evidenced by:	G0706		

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G0706	Continued from page 21 Based on observation, record review, and interview, the Registered Nurse (RN) failed to conduct a through and complete nursing assessment for 1 of 1 home visit observations of a skilled nurse visit (#1). An undated agency job description titled "Position: Registered Nurse" indicated but was not limited to "… Essential Functions/Areas of Accountability … 2. Consistently demonstrates competency with technical nursing skills … a. Assessment skills …." Chippewa Valley Technical College (no date). Nursing Skills. Retrieved 10/27/21 from https://wtcs.pressbooks.pub/nursingskills/. "… Enteral Tube Management … nurses perform additional interventions to prevent aspiration. The American Association of Critical Care Nurses recommends the following guidelines to reduce the risk for aspiration: … Assess feeding tube placement … Assess for gastrointestinal intolerance … Measurement of gastric residual volume (GRV) [measurement of enteral feeding remaining in stomach] is performed by using a 60-mL syringe to aspirate stomach contents through the tube. It has traditionally been used to assess aspiration risk …." The clinical record of Patient #1 was reviewed on 10/20/2021 and indicated a start of care date of 9/14/21 with patient diagnoses including but not limited to presence of a G-tube (medical tube inserted into the stomach to assist with nutrition), adult failure to thrive, dysphagia (difficulty swallowing), and urinary tract infections. The record included a plan of care for the certification period 9/14/21 – 11/12/21. The POC's service orders indicated the patient was to receive skilled nursing visits, 1 visit per week for 9 weeks, for "skilled nursing assessment … Assess/monitor … nutrition and hydration. Instruct [patient and/or caregiver] on G-tube care, feedings and flushes …." A home visit observation was conducted on 10/19/21 at 1:27 PM with Patient #1 and Registered Nurse (RN) #1. During the visit, Patient #1 was observed to have a G-tube (medical tube inserted into the stomach to assist with nutrition) present in the left upper abdomen. RN #1 failed to assess the patient's gastric residual volume directly or discuss with Family Member #1 if GRV was being assessed.	G0706		

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G0706	Continued from page 22 An interview was conducted on 10/20/21 with the Administrator, Clinical Manager, and Administrative Assistant #1. During the interview, the Clinical Manager and Administrator confirmed the agency did not expect nurses to assess for gastric residual volume unless ordered by the patient's provider.	G0706		
G0798	Home health aide assignments and duties CFR(s): 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the home health aide (HHA) care plan was detailed, patient specific, and followed the agency's policy for 1 of 1 records of patients receiving HHA services (#3). An undated agency policy titled "Home Health Aide Care Plan" indicated but was not limited to: "Policy: A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse or Therapist … Special Instructions: 1. Following the initial nursing assessment and consultation with the patient/caregiver, a written plan identifying personal care and supportive care services are prepared … 2. The Care Plan shall be developed in plain, non-technical lay terms and identify the duties to be performed …." The clinical record of Patient #3 was reviewed on 10/20/21 and indicated a start of care date of 2/26/18 with patient diagnoses including but not limited to multiple sclerosis, hyperglycemia [high blood sugar], and urine retention. The record included a plan of care (POC) for the recertification period 10/8/21 – 12/6/21, which indicated the patient was to receive skilled	G0798		

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G0798	Continued from page 23 nursing (SN) and home health aide services. The POC indicated the aide tasks were to include "… assist with ADLs, bathing, meal prep, meal set up, light housekeeping, monitor for choking or s/s [signs and/or symptoms] of infection. HHA to report any concerns to SN … [Patient #3] is mostly bedfast and requires around the clock care. She is dependent for any transfers. HHA to monitor skin for any breakdown and report any wounds to SN …." A home visit observation was conducted on 10/20/21 at 9:55 AM with Patient #3 and Home Health Aide #1. During the visit, HHA #1 was observed emptying the patient's urostomy. The aide confirmed she would change the patient's urostomy bag twice a week on Tuesdays and Thursdays. The clinical record included an "Aide Care Plan" documented and signed by RN #2 on 10/11/21. The care plan indicated but was not limited to "… Precautionary and Other Pertinent Information … Watch for hyper/hypoglycemia [high and low blood sugar] … Assignment: … Bed Bath – Partial/Complete … Ostomy Care …." The care plan failed to follow the agency's policy by including non – technical lay terms (hyper/hypoglycemia); failed to be patient specific and detailed by failing to evidence the specific signs and symptoms of hyperglycemia and hypoglycemia to report, failing to evidence whether the aide was to perform a partial or complete bath, failing to evidence specific care to be performed to the patient's urostomy (emptying bag, changing pouch, specific signs and symptoms to report, etc); and failed to include all tasks included in the POC by failing to evidence the tasks for monitoring for chocking and signs and symptoms of infection. An interview was conducted on 10/22/21 at 3:05 PM with the Administrator, Clinical Manager, Alternate Administrator, and Administrative Assistant #1. During the interview, the Clinical Manager confirmed the aide care plan should be detailed and patient specific.	G0798		
G0800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner;	G0800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/25/2021

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G0800	Continued from page 24 (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the home health aide (HHA) completed tasks only according to the aide care plan for 1 of 1 active records of a patient receiving home health aide services (#3). An undated agency policy titled "Home Health Aide Care Plan" indicated but was not limited to: "Policy: A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse or Therapist. All home health aide staff will follow the identified plan … Special Instructions: … 6. The Home Health Aide cannot be responsible for performing any procedure that is not assigned to him/her in writing by the Registered Nurse/Therapist …." An undated agency job description titled "Position: Home Health Aide" indicated by was not limited to "… Position Summary: Provides personal care services under the direction of the Registered Nurse or Therapist … Essential Functions/Areas of Accountability … 4. Assists in the administration of medications that are ordinarily self-administered under the direction and supervision of the Registered Nurse (per state nurse practice laws and Agency policy) …." The clinical record of Patient #3 was reviewed on 10/20/21 and indicated a start of care date of 2/26/18 with patient diagnoses including but not limited to multiple sclerosis, hyperglycemia [high blood sugar], and urine retention. The record included a plan of care (POC) for the recertification period 10/8/21 – 12/6/21, which indicated the patient was to receive skilled nursing (SN) and home health aide services. The POC indicated the aide tasks were to include "… assist with ADLs, bathing, meal prep, meal set up, light housekeeping, monitor for choking or s/s [signs and/or symptoms] of infection. HHA to report any concerns to SN … [Patient #3] is mostly	G0800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/25/2021

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G0800	Continued from page 25 bedfast and requires around the clock care. She is dependent for any transfers. HHA to monitor skin for any breakdown and report any wounds to SN ….” The record also included an “Aide Care Plan” documented and signed by RN #2 on 10/11/21. The care plan indicated the aide tasks to be completed “Every Visit” were “Temperature … Pulse … Respirations … Blood Pressure … Bed Bath – Partial/Complete … Personal Care … Assist with Dressing … Hair Care … Skin Care … Check Pressure Areas … Oral Care … Assist with Elimination … Ostomy Care … Mobility Assist: Bed … Positioning – Encourage: Assist every 2 hrs … Meal Preparation … Assist with Feeding … Encourage Fluids … Light Housekeeping,” and the task “Shampoo” was to be completed “Weekly.” A home visit observation was conducted on 10/20/21 at 9:55 AM with Patient #3 and Home Health Aide #1. During the visit, HHA #1 confirmed the patient intermittently had a “heat rash” and the aide would apply either a diaper rash cream or Nystatin (medication used to treat fungal infections) powder to the area. The aide confirmed she applied the Nystatin powder when the rash was “not that bad.” The aide care plan failed to evidence the aide was to apply any creams or lotions and directions on when to apply. The visit notes for HHA visits conducted during the certification period 8/9/21 – 10/7/21 indicated HHA #1 completed 26 visits for Patient #3. All 26 visit notes failed to evidence the aide obtained the patient’s temperature, pulse, respirations, and blood pressure as directed on the care plan to be completed with every visit. An interview was conducted on 10/22/21 at 3:05 PM with the Administrator, Clinical Manager, Alternate Administrator, and Administrative Assistant #1. During the interview, the Clinical Manager confirmed HHAs should only complete tasks as indicated on the aide care plan and within their scope of practice.	G0800		