

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157579	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/15/2022
NAME OF PROVIDER OR SUPPLIER CJ'S ABUNDANT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 CENTRAL AVENUE, ANDERSON, IN, 46016	
(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 Department of Health in accordance with 42 CFR S 484.102. Survey Dates: February 1, 2, 9, 10, 11, 14, 15; 2022 At this Emergency Preparedness survey, CJ's Abundant Care was found not in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 484.102. QR by Area 2 on 3/11/2022	E0000		2022-03-11
G0000	This was a Federal recertification, State re-licensure of a home health agency The survey was partially extended on February 11, 2022 at 3:45 PM.	G0000		2022-03-11

	<p>Survey Dates: February 1, 2, 9, 10, 11, 14, 15; 2022</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 17.</p> <p>QA by Area 2 on 3/11/2022</p>			
<p>E0018</p>	<p>Procedures for Tracking of Staff and Patients</p> <p>494.62(b)(1)</p> <p>§403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]</p> <p>[(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.</p> <p>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.</p>	<p>E0018</p>	<p>Agency Administrator held a nursing and office staff in-service/meeting on 02/17/2022 and reviewed the agency emergency management policies. The administrator created and presented an emergency preparedness on staff employee tracking to be utilized in the event of an emergency plan activation. In the event of an emergency plan activation the administrator will assign personnel to contact all on duty staff upon activation and at least every two hours until the plan is deactivated. The agency emergency preparedness plan will continue to be reviewed/updated every 2 years during the agency QA-PI meeting and as needed. All emergency preparedness activations will be overseen by the administrator. (see attached meeting minutes from 02/17/2022, policies reviewed, and on staff employee tracking form)</p>	<p>2022-02-17</p>

*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.

(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.

(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.

Based on observation, record review, and interview, the home health agency failed to follow their emergency preparedness policies and procedures related to the system to track the location of on-duty staff in the agency's care during an emergency, which had the potential to affect all agency employees and patients.

1. An undated agency policy titled Emergency Management Policy, numbered B-400, included but was not limited to & C J s Abundant Care will have an identified plan in place to insure [sic] the safety and well-being of clients and employees during periods of an emergency or disaster that disrupts agency services & Special Instructions:

include, but are not limited to: a. Adverse weather such as & blizzards, and storms & 10. In the event of impending hurricane, tornado, flood, or unsafe travel conditions, the Director of Nursing or designee will inform staff to stay in touch with the office to obtain further instructions &.

2. An undated agency document titled Emergency Preparedness Plan included but was not limited to All Hazard Emergency Preparedness Policy & Examples of incidents include: & Weather related emergencies including snow, ice storm & Plan Activation Emergency Call Down Procedure & Once the emergency response plan is activated, the Administrator will notify the Office Manager to initiate the staff call down procedure. Office manager will notify the Case Managers and Staffing Coordinator, and then each will notify persons listed below them on the calling list. If they are unable to reach an employee & on the telephone, they will proceed to the next listed person on the list. After completing the list, case managers and staffing coordinators will try every 5 [minutes] to reach the employee & not previously reached & Emergency Assessments: Each nurse or aide making home visits to patients must check in with the Agency office with an update every hour &.

3. An undated, untitled agency document received from Office Manager #1 on 2/9/22 at 3:55 PM included but was not limited to, Emergency preparedness activation due to expected severe winter weather 2/2/22 2/4/22 & Staffing Manager has been instructed to notify all field staff that the Emergency Preparedness Plan has been activated and to make sure their patients have enough supplies &.

4. A home visit observation was conducted on 2/2/2022 at 11:45 AM with Patient #2 (start of care 8/25/2020) and Home Health Aide #2. During the visit, Home Health Aide #2 confirmed they received a text message from the agency which indicated the agency s Emergency Preparedness Plan was activated, and the employee was to check with all their patients to ensure the patient had all food and supplies needed by the end of the day.

5. An interview was conducted on 2/15/22 at 2:15 PM with the Clinical Manager and Office Manager #1. During the interview, Office

	<p>field staff of the activation of the emergency preparedness plan through a mass texting application. The office manager confirmed the agency was unable to confirm whether all employees received the notification when using the mass texting application and the agency did not verify the location of all on-duty staff when the emergency preparedness plan was activated or during the activation period.</p>			
<p>G0574</p>	<p>Plan of care must include the following 484.60(a)(2)(i-xvi)</p> <p>The individualized plan of care must include the following:</p> <ul style="list-style-type: none"> (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; 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. <p>Based on record review and interview, the home health agency failed to ensure the plan of care</p>	<p>G0574</p>	<p>Administrator in-serviced all active nursing staff on 02/17/2022 on patient goals being specific and measurable to patient diagnosis, all patient diagnoses history being clearly noted on the patients plan of care, and all ordered medications will have a supporting diagnosis. In the event the patient does not have a supporting diagnosis for the use of ordered medications the nursing staff member will immediately clarify with the physician the reason for use of the medication. Agency administrator reviewed comprehensive assessment and care plan policies with all active nursing staff on 02/17/2022. Agency administrator completed a competency evaluation on nursing staff during their next scheduled assessment. Administrator will review all completed nursing assessments/visits upon submission of the completed assessment/visit to the agency, to maintain compliance. (see attached meeting minutes from 02/17/2022, policies reviewed, and completed nursing competency evaluations)</p>	<p>2022-02-17</p>

contained all pertinent diagnoses and patient-specific and measurable goals for 5 of 5 active records reviewed (Patients #1, 2, 3, 4, 5).

1. An agency policy titled Plan of Care and numbered C-580 included but not limited to & Special Instructions: 1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services. 2. The Plan of Care shall be completed in full to include: a. All pertinent diagnosis(es), principle and secondary, including dates of onset & p. Treatment goals &.

2. The clinical record of Patient #1 was reviewed on 02/9/2022 and indicated a start of care date 6/13/17 with patient diagnoses including but not limited to chronic pain syndrome, fibromyalgia, urinary incontinence (inability to control urination), Irritable Bowel Syndrome (IBS) with diarrhea, and high blood pressure. The record included a plan of care for the certification period 01/18/22 3/18/22 and comprehensive recertification assessment completed on 01/14/22 by the Alternate Clinical Manager. The comprehensive assessment included an active medication list which indicated the patient was taking ammonium lactate (cream or lotion used to treat dry skin conditions), ketoconazole (used to treat fungal skin infections), levetiracetam (given to treat seizures), pantoprazole (used to treat Gastro Esophageal Reflux Disease (GERD)), and venlafaxine (given to

treat depression). The plan of care failed to evidence diagnoses related to the above medications.

The plan of care indicated the patient s goals included but were not limited to Patent suprapubic [catheter, used to empty the bladder through a surgically made stoma in the lower abdomen] with no signs and symptoms of infection, the patient will remain safe in home throughout certification period, personal hygiene needs would be met throughout certification period, adequate nutrition throughout certification period, stable cardiopulmonary status as evidenced by vital signs within normal limits, and blood sugars to remain within normal limits throughout the certification period. The goals failed to be measurable and patient specific.

A home visit observation was conducted on 2/2/2022 at 10:30 AM with Patient #1 and Home Health Aide #1. No suprapubic catheter was noted during the home visit.

3. The clinical record of Patient #2 was reviewed on 2/9/22 and indicated a start of care date 8/25/2020 with patient diagnoses including but not limited to macular degeneration, Type 2 Diabetes Mellitus, and chronic pain syndrome. The record included a plan of care for the certification period 12/18/21 2/15/22. The plan of care indicated the patient s goals included blood sugar within normal limits throughout the certification

period, adequate hygiene maintained with home health aide assist throughout the certification period, patient will remain safe at home with agency assist throughout the certification period, and stable cardiopulmonary status as evidenced by vital signs within normal limits. The goals failed to be patient specific and measurable.

4. The clinical record of Patient #3 was reviewed on 2/10/22 and indicated a start of care date 7/14/21 with patient diagnoses including but not limited to Chronic Obstructive Pulmonary Disease (COPD), osteoarthritis, high blood pressure, and lung cancer. The record included a plan of care for the certification period 1/10/22 3/10/22. The plan of care indicated the patient s goals included but were not limited to the patient s personal hygiene needs met with agency assist throughout the certification period and vital signs within normal limits throughout the certification period. The goals failed to be patient specific and measurable.

5. The clinical record of Patient #4 was reviewed on 2/11/22 and indicated a start of care date 7/30/18 with patient diagnoses including but not limited to Type 2 Diabetes Mellitus, anxiety, depression, and high blood pressure. The record included a plan of care for the certification period 1/10/22 3/10/22. The plan of care included an active medication list which indicated the patient was taking alendronate (given to treat osteoporosis), betamethasone valerate (given to

treat various skin conditions, typically as a cream or ointment applied to the skin), Calcitrate (given to treat osteoporosis or low calcium levels), gentamicin topical cream (antibiotic given to treat bacterial infections), and nystatin topical cream and powder (given to treat fungal infections). The plan of care failed to evidence diagnoses related to the above medications.

The plan of care indicated the patient's goals included but were not limited to the patient's personal hygiene needs met with agency assist throughout certification period, the patient would be compliant with medications throughout the certification period, stable cardiopulmonary function as evidenced by vital signs within normal limits, and blood sugars within normal limits throughout the certification period. The goals failed to be patient specific and measurable.

6. The clinical record of Patient #5 was reviewed on 2/11/22 and indicated a start of care date 2/18/21 with patient diagnoses including but not limited to COPD, lung cancer, Type 2 Diabetes Mellitus, and alcohol dependence. The record included a plan of care for the certification period 12/15/21 2/12/22. The plan of care indicated the patient's goals included but were not limited to the patient would remain safe in home with assist from agency, , the patient would have a stable cardiopulmonary status as evidenced by vital signs within

	<p>blood sugar within normal limits throughout the certification period, and the patient will maintain adequate nutrition throughout the certification period. The goals failed to be patient specific and measurable.</p> <p>7. An interview was conducted on 2/15/22 at 2:15 PM with the Clinical Manager and Office Manager #1. During the interview, the Clinical Manager confirmed the plan of care should include diagnoses for all patient conditions and if a patient was on a medication without a corresponding diagnosis, the agency expectation was the nurse should request a diagnosis from the patient's physician. The Clinical Manager also confirmed the plan of care should include measurable and patient specific goals.</p> <p>17-13-1(a)(1)(B)</p>			
<p>G0682</p>	<p>Infection Prevention</p> <p>484.70(a)</p> <p>Standard: Infection Prevention.</p> <p>The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.</p> <p>Based on observation, record review, and interview, the home health agency failed to ensure all staff followed standard precautions and agency infection prevention policies and procedures for 3 of 3 home visit observations conducted (Patients #1, 2).</p> <p>1. An agency policy titled Infection Prevention/Control, numbered B-403, included but not limited to Policy: Agency will observe the recommended precautions for home care as identified by the Centers for Disease Control and</p>	<p>G0682</p>	<p>Agency administrator held an in-service with nursing and office staff on 02/17/2022 and reviewed infection control, standard precautions, and handwashing policies. Agency administrator instructed HR Ashton Huston to schedule an in-service for all staff on infection control, standard precautions, and handwashing policies as soon as possible. Agency administrator checked off nursing staff on handwashing and bag technique on 02/17/2022. Agency administrator and alt administrator in-serviced all other staff on infection control, standard precautions, and handwashing on or by 03/11/2022. Infection prevention/control practices will be continuously monitored by agency nursing staff upon home health aide supervisory visits and by continued in-servicing. (see attached meeting minutes from 02/17/2022, policies reviewed, and completed nursing check offs)</p>	<p>2022-03-11</p>

One & 2. Hands are washed if contaminated with blood or body fluid, immediately after gloves are removed, between client contacts, and when indicated to prevent transfer of microorganisms between other clients or the environment &.

2. Centers for Disease Control and Prevention (Updated 4/30/21). Wearing a Mask. Retrieved 2/16/22 from www.cdc.gov. Wear a Mask the Right Way & The mask must cover your nose. The mask must cover your mouth & The mask must be snug on your face &.

3. McGoldrick (1/2014). Bag Technique: Preventing and Controlling Infections in Home Care and Hospice. Retrieved 2/16/22 from www.journals.lww.com. & Bag Technique & 5. Clean the equipment and supplies &.

4. A home visit observation was conducted on 2/2/2022 at 10:30 AM with Patient #1 (start of care 6/13/17) and Home Health Aide #1. During the visit, Home Health Aide #1 was observed on one occasion failing to perform hand hygiene prior to donning gloves.

5. A home visit observation was conducted on 2/2/2022 at 11:45 AM with Patient #2 (start of care 8/25/2020) and Home Health Aide #2. During the visit, Home Health Aide #2 was observed on two occasions with her surgical mask below her nose. The aide failed to promptly adjust the mask to the appropriate location (covering both nose and mouth).

6. A home visit observation was conducted on 02/11/2022 at 10:30 AM with Patient #2 and the Alternate Clinical Manager. At the end of the visit, as the Alternate Clinical Manager was collecting her belongings, the nurse was observed cleaning her laptop, folder, and pen, and then immediately placed the items back into her nursing bag.

7. An interview was conducted on 2/11/2022 at 12:40 PM with the Clinical Manager and Office

	<p>Manager #1. During the interview, the Clinical Manager confirmed staff should perform hand hygiene prior to donning gloves, staff should perform hand hygiene then adjust the face mask immediately if it moves from covering their nose and mouth, and staff should allow cleaned equipment to dry prior to returning the items to the nursing bag.</p> <p>17-12-1(m)</p>			
<p>G0706</p>	<p>Interdisciplinary assessment of the patient 484.75(b)(1)</p> <p>Ongoing interdisciplinary assessment of the patient;</p> <p>Based on observation, record review, and interview, the Registered Nurse (RN) failed to conduct a complete and thorough physical assessment for 1 of 1 home visit observations of a skilled nurse visit (Patient #2) and 3 of 5 active records reviewed (Patients #1, 2, 5).</p> <p>1. An undated agency job description titled Registered Nurse indicated but was not limited to Primary Purpose: The primary purpose of the registered nurse (RN) is to provide high quality nursing care to assigned patients in their place of residence & Performance Responsibilities: & 9. Perform initial and on-going patient assessments &.</p> <p>2. The clinical record of Patient #1 was reviewed on 2/9/2022 and indicated a start of care date 6/13/17 with patient diagnoses including but not limited to chronic pain syndrome, fibromyalgia, osteoarthritis, lumbar disc degeneration, urinary incontinence (inability to control urination), Irritable Bowel Syndrome (IBS) with diarrhea, and high blood pressure. The record included a plan of care for the certification period 1/18/22 3/18/22 and comprehensive recertification assessment completed on 1/14/22 by the Alternate Clinical Manager. The assessment failed to evidence a complete and thorough assessment of the patient s musculoskeletal status and conditions (fibromyalgia, osteoarthritis, lumbar disc degeneration).</p> <p>The comprehensive assessment included an active medication list which indicated the patient was taking ammonium lactate (cream or lotion</p>	<p>G0706</p>	<p>Agency administrator held an in-service/meeting on 02/17/2022 and reviewed the agencies comprehensive assessment policy with the agencies active nursing staff. Agency administrator completed a competency evaluation on the active nursing staff upon their earliest scheduled visit. The agency administrator in-serviced active nursing staff on assessing/educating/follow up with the patient including but not limited to changes in medications, diagnoses, and condition. Agency administrator will review all completed nursing assessments/visits upon completion and submission of the visit to the agency, to monitor compliance with proper completion of nursing assessments. The agency administrator will complete a competency evaluation on all active nursing staff at least annually, to maintain compliance with completing proper nursing assessments. (see attached meeting minutes from 02/17/2022, policies reviewed, and completed nursing competency evaluations)</p>	<p>2022-03-01</p>

(used to treat fungal skin infections), levetiracetam (given to treat seizures), pantoprazole (used to treat Gastro Esophageal Reflux Disease (GERD)), and venlafaxine (given to treat depression). The assessment failed to evidence the nurse assessed and documented the patient's current status and the presence or absence of signs and symptoms for the above conditions.

3. The clinical record of Patient #2 was reviewed on 2/9/22 and indicated a start of care date 8/25/2020 with patient diagnoses including but not limited to macular degeneration, Type 2 Diabetes Mellitus, and chronic pain syndrome. The record included a plan of care for the certification period 12/18/21 - 2/15/22 and comprehensive recertification assessment completed on 12/14/21 by the Alternate Clinical Manager. The assessment indicated the patient was prescribed an antibiotic and cough suppressant due to an upper respiratory infection (URI). The assessment failed to evidence a complete assessment for signs and symptoms of the URI (runny nose, sneezing, congestion, fatigue, etc).

A home visit observation was conducted on 2/11/2022 at 10:30 AM with Patient #2 and the Alternate Clinical Manager. During the visit, the Alternate Clinical Manager was observed assessing the patient's lung sounds by listening to 4 lung lobes posteriorly and 1 lobe anteriorly. The patient reported diarrhea and the nurse noted redness but no open areas to the patient's inner gluteal folds (buttocks). The nurse failed to assess the patient's diarrhea symptoms (frequency and consistency of stool, presence or absence of blood, etc) and failed to assess if the patient was applying any topical creams or ointments to the irritated skin. The Alternate Clinical Manager also conducted a medication reconciliation during the visit. The nurse failed to verify the patient's prescription for benzonatate (medication given to suppress cough) during the visit, which was listed on the patient's medication list and observed in the home.

4. The clinical record of Patient #5 was reviewed on 2/11/22 and indicated a start of care date 2/18/21 with patient diagnoses including but not limited to COPD, lung cancer, Type 2 Diabetes Mellitus, and alcohol dependence. The record included a plan of care for the certification period 12/15/21 - 2/12/22 and recertification comprehensive assessment completed on 12/10/21 by the Alternate Clinical

Manager. The assessment included a medication list which indicated the patient was taking mirtazapine (given to treat depression). The assessment failed to evidence the status of the patient's depression and the presence or absence of depression symptoms.

5. An interview was conducted on 2/11/22 at 12:40 PM with the Clinical Manager and Office Manager #1. During the interview, the Clinical Manager confirmed the nurse should listen to all lobes both anteriorly and posteriorly when assessing the patient's lung sounds, should conduct a thorough assessment if a patient reported diarrhea, and should assess whether a patient was applying any treatment to a new skin irritation or wound. The Clinical Manager also confirmed the nurse should verify all medications on the medication list and present within the patient's home when conducting a medication reconciliation.

6. An interview was conducted on 2/15/22 at 2:15 PM with the Clinical Manager and Office Manager #1. During the interview, the Clinical Manager confirmed the comprehensive assessment should include an assessment of any new diagnoses or indicate any newly resolved diagnosis.

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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