STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K164	A. BUILDING B. WING	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE TREE HOME HEALTH CARE SERVICES, LLC	5257 N TACOMA DR SUITE 4, INDIANAPOLIS, IN, 46220

(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 484.102 Survey Dates: 09-21-2023, 09-22-2023, and 09-25-2023 Active Census: 15 At this Emergency Preparedness survey, Apple Tree Home Health LLC was not found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR by Area 3 on 09/28/2023.	E0000		

E0006	Plan Based on All Hazards Risk Assessment 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk	E0006	The correction for this deficiency will be corrected by 10/26/2023. All active patients will have a risk assessment completed by the date above and each risk assessments will be reviewed annually and completed by October 26th of the current year. The administrator will be responsible for making sure this deficiency will not occur again.	2023-10-26

consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.

*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.

(2) Include strategies for addressing emergency events identified by the risk assessment.

*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.

(2) Include strategies for addressing emergency events identified by the risk assessment.

Based on record review and interview the agency failed to update and review a community-based risk assessment for 2 years (2022-present).

Findings include:

1. A policy received from the Administrator on 09-21-2023 titled " Hazard Vulnerability"

	indicated but was not limited to "The agency will re-visit and revise its Hazards and Vulnerability Analysis annually and as appropriate…." 2. A review of the Agency's Emergency Preparedness Materials failed to evidence any community-based risk assessment occurred for the years 2021, 2022, and present. 3. During an interview on 09-25-2023 at 10:07 AM, the Administrator reported the Agency's office has not done a community-based risk assessment since the office moved from Fort Wayne to Indianapolis approximately 2 ½ years ago.			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: 09-21-2023,-09-22-2023, and 09-25-2023	G0000		

	12-Month Unduplicated Skilled Admissions: 17 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. QR by Area 3 on 09/28/2023.			
G0682	Infection Prevention 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. Based on observation, record review and interview, the agency failed to ensure home health aide (HHA) 3 followed standard infection prevention precautions while performing a bed bath for 1 of 1 bed bath observation, with the potential to affect all patients who	G0682	For this deficiency Apple Tree Home Health Services will be retraining all direct care staff on the agencies policies on infection control as well as as the CDC hand hygiene's guidelines. All direct care staff will be involved with direct in-services training that will be preformed by the clinical Manager and overseen by the Administrator. This training will be completed by 10/26/2023, with subsequent training to be performed and done every 6 months for 1 year.	2023-10-26

require a bed bath.

Findings include:

1. A review of Centers for Disease Control and Prevention (CDC) hand hygiene guidelines (retrieved from https: //www.cdc.gov/ handhygiene/ providers/ index.html) indicated hand hygiene and clean gloves were required after moving from a soiled body part to a clean body part

2. An observation of a bed bath occurred 9/22/2023 at 9:30 AM with HHA 3 with Patient #5. At the beginning of the bed bath, HHA 3 washed hands, put on gloves, and brought a basin of warm water to the patient's bedside. HHA 3 washed the patient, excluding the genital/ anal area. HHA 3 opened the door with soiled gloves on, replaced the water in the basin, washed hands for less than 12 seconds and put on new gloves. HHA 3 removed the incontinence brief, washed the genital/ anal area, and applied a moisture barrier to the patient's bottom. HHA 3 wiped gloves on a used towel and put Patient #5 into a new brief. HHA 3 opened the door with soiled gloves and dumped the

	basin of water. HHA 3 then applied lotion and dressed patient. HHA 3 transferred the patient to a wheelchair and pushed the patient into the dining room. HHA 3 picked up a food container, put it down, removed soiled gloves, washed hands, and donned clean gloves prior to feeding the patient. 3. During an interview at the time of the visit, HHA 3 confirmed he/ she failed to change gloves and wash hands after bathing the patient. 410 IAC 17 - 12 - 1(m)			
N0000	Initial Comments This visit was for a State Re-Licensure survey of a Home Health Provider. Survey Dates: 09-21-2023,-09-22-2023, and 09-25-2023	N0000		

	12-Month Unduplicated Skilled Admissions: 17 QR by Area 3 on 09/28/2023.			
N9999	Final Observations Based on record review and interview the agency failed to provide 3 hours of annual in-service training with an approved Dementia Training program for 3 Home Health Aides (HHA) providing care for patients with cognitive disorders (HHAs 1,2, and 3) and 6 hours of approved dementia training for one newly hired HAA providing care for patients with cognitive disorders. (HHA 3) Findings include: 1. A review of IC 16-27-1.5-5	N9999	st three courses will be given to all Home Health aides by10/26/2023 and all tests for the 1st three courses will be complet5edby each aide by 11/03/2023. Each test for the courses will be graded by theClinical Manager and shall be passed with at least 80% accuracy rating. The remainingcourses will be given to the Home Health aides by the Clinical Manager by11/26/2023 with each course being completed with over 80% accuracy by12/31/2023. To ensure that these courses are not missed in the future and thatthe agency is complying with regulations. The Clinical Manager andAdministrator will be adding all courses to the in-services training for allHome Health Aides annually.	2023-10-26

included but was not limited to " Sec. 5. (a) This section applies to a registered home health aide who: (1) is employed as a home health aide; and (2) provides care to an individual who has been diagnosed with or experiences symptoms of Alzheimer's disease, dementia, or a related cognitive disorder. (b) As used in this section, "approved dementia training" refers to a dementia training program:(1) for use in training home health aides in the care of individuals described in subsection (a)(2); and(2) that has been approved by the state department under subsection (f(c) Not later than sixty (60) days after the date on which a home health aide is initially hired to care for an individual with Alzheimer's disease, dementia, or a related cognitive disorder, the home health aide shall complete at least six (6) hours of approved dementia training.(d) Before December 31 of each year, a home health aide who has been employed as a home health aide for at least one (1) year shall complete at least three (3) hours of approved dementia training(e) A home health aide who:(1) has received the training required

	by subsections (c) and (d)(2) has been employed as a home health aide for at least twenty-four (24) consecutive months; and(3) is hired by a home health agency;is not required to repeat the training required by this section.(f) The state department shall do the following:(1) Identify and approve each dementia training ...program that meets the following requirements:(h) An entity that provides approved dementia training shall provide to each home health aide who successfully completes the training a certificate of completion.(i) A home health aide: (1) is responsible for maintaining the home health aide's certificate of completion; and (2) may use the certificate of completion as proof of compliance with this section. 2. A review of the personnel file for Home Health aide 1 (HHA), evidenced a hire date of 12-28-2017 and an annual training record for the years 2022 to present contained no evidence of an approved dementia training program. 3. A review of the personnel file for HHA 2 evidenced a hire date			

of 05-25-2020 and an annual training record from 2022 to present with a certificate for dementia training from Entity H, an online college, for 1.6 contact hours dated 09-25-2023.

4. A review of the personnel file for HHA 4, evidenced a hire date of 04-13-2018 and annual training record from 2022 to present and no evidence of dementia training .

5. A review of the personnel file for HHA 5 evidenced a hire date of 07-11-2023 and no evidence of dementia training completed.

6. During an interview with the Administrator on 09-25-2023 at 1:15 PM she reported that all aides complete one hour annually but the certificate tells us exactly how long it takes to complete the training. She reported they utilize Entity H, a community technical college's online course for training not an approved dementia training course.

When queried if Home Health Aides 1,2,4, and 5 cared for patients with cognitive

	did. At 1:30 PM the administrator returned to report she had consulted a source and confirmed they were not utilizing an approved dementia training program or completing the required hours annually.			

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
Lesley Hayes	Administrator	10/16/2023 11:04:28 AM