STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 24141521	(X2) MULTIPLE CONSTRUCTION A.BUILDING B.WING	(X3) DATE SURVEY COMPLETED 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE HOME HEALTH	3135 EAST WABASH AVENUE, TERRE HAUTE, Indiana, 47803

(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
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Deemed Home Health provider. Survey Dates: 05/29/2024 to 06/03/2024 12-month Unduplicated Skilled Admissions: 72 QR Completed on 06/11/2024 by A4	N0000		
N0445	Home health agency administration/management CFR(s): 410 IAC 17-12-1 (c)(2) Rule 12 Sec. 1(c)(2) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (2) Maintain ongoing liaison among the governing body and the staff. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the Administrator failed to initiate and maintain communication with the Governing Body, affecting 1 of 1 agency. Findings include: A document titled "Job Description/Evaluation Administrator" indicated that one of the Administrator's essential functions is to provide counsel to the Board of Directors regarding the community's needs, financial needs, professional practices, and health planning. During the entrance conference on 05/29/2024 at 9:22 AM, the Administrator indicated she did not know who the Governing Body was and would have to look it up; she indicated she had no direct communication with the Governing Body. The Administrator indicated she communicated with the Regional Director of Business Operations. At the end of the entrance conference, the	N0445	Home health agency administration/management The Regional Director of Business Development will be responsible for ensuring the Administrator is aware of who the members of the Governing Body consist of and how to communicate directly with them. The Regional Director of Business Development in-serviced the Administrator on Policy AD.036 Responsibilities of the Administrator. Specifically, "The Agency Administrator will assume overall responsibility and authority for the day to day operations of the Agency, including administrative and leadership functions, supervision of the established organizational plan and responsibility for ongoing communication with the Governing Body and the entire Agency staff." "K. Maintaining an ongoing liaison with the Governing Body, staff members and the community." "II. The Administrator will identify resources needed to implement his or her responsibilities and will notify the Governing Body of these needs." "III. The Administrator will notify the Governing Body immediately if he or she is unable to fulfill his or her responsibilities." The Regional Director of Business Development will monitor for ongoing compliance by conferencing with the Administrator quarterly to assure that they are aware of who the Governing Body is and assess for issues in contacting the Governing Body. CONTINUED ON PAGE 2 OF 11	07.03.24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gina Abeisinger RN	Administrator	6/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 24141521	(X2) MULTIPLE CONSTRUCTION A.BUILDING B.WING	(X3) DATE SURVEY COMPLETED 06/03/2024

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N0445	Continued from page 1 Administrator provided the names of the Governing Body, which she received from the Regional Clinical Director by text. During an interview on 05/31/2024 at 11 :00 AM, the Administrator indicated she started in October 2023 and has not needed to communicate with the Governing Body. She indicated, that she communicates with the Regional Director of Business Operations; who then would communicate with the Governing Body if needed since most items fall under the scope of the Regional Director of Business Operations.	N0445		
N0470	Home health agency administration/management CFR(s): 410 IAC 17-12-1 (m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to maintain infection control on 3 of 3 home visits. (Patient# 5, #6, #8) Findings include: 1. A revised 08/2022 policy titled "Infection Control" indicated the agency would follow accepted standards of practice, including standard precautions to prevent transmission of infections and infectious diseases. 2. The Centers for Disease Control (CDC)website indicates that Standard Precautions should be used to protect healthcare providers from infection and prevent the spread of infection from patient to patient. The CDC website indicates that hand hygiene is part of standard precautions that include hand washing before and after gloving, proper handling, cleaning, and disinfecting patient care equipment, and cleaning and disinfecting the environment. (https://www.cdc.gov/infection-control/hcp/basics/standard-precautions.html Updated:04/03/2024) 3. During an observation on 05/30/2024 at 10:20 AM, Registered Nurse (RN) 1 placed dirty vital equipment (blood pressure cuff, thermometer, and oximeter) directly onto the tabletop, with no barrier. RN 1 proceeded to remove the stethoscope from around his neck and performed a head-to-toe assessment on Patient	N0470	Home health administration/management The Administrator is responsible for ensuring infection control is maintained during all home visits. Administrator in-serviced all clinical staff on Policy CC.015 Infection Control to review standard precautions to prevent the transmission of infections and communicable diseases. In addition: All clinical staff will be in-serviced on Case Conference titled "Bag Technique". Specifically: "Proper bag technique is an essential part of providing effective care as a home health provider. Every time you visit a patient's home, you should make sure you are following effective bag technique to avoid any cross contamination and keep your patients healthy." All clinical staff will be assigned a refresher courses via Med-Bridge on topics titled "Bag Technique: Preventing and Controlling the Spread of Infection" and "Hand Hygiene: The Key to Infection Control". The Administrator or designee will make a home visit with each clinician providing care to assure appropriate precautions for infection control are being followed for 1 month. Target threshold is 100%. Once the threshold is met, the Administrator or designee will make random supervisory visits on 10% of patients receiving care to monitor for ongoing compliance. CONTINUED ON PAGE 3 OF 11	07.03.24

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N0470	Continued from page 2 #5, RN failed to disinfect the stethoscope prior to and after patient use. RN 1 failed to perform hand hygiene before and after having contact with the patient. 4. During an observation on 05/31/2024 at 1:03 PM, the Administrator removed the stethoscope from around her neck and performed a head-to-toe assessment on Patient #8 The Administrator failed to clean the stethoscope before and after use on Patient #6. The Administrator removed her gloves after assessing the patient and donned new gloves without performing hand hygiene. The Administrator failed to maintain infection control during the home visit. During an interview on 06/03/2024 at 8:45 AM, the Administrator indicated she was diligent about using alcohol gel while providing patient care and expressed being surprised she missed hand hygiene. 5. During an observation on 05/31/2024 at 3:05 PM, RN 1 removed the stethoscope from around his neck and performed a head-to-toe assessment on Patient #8. RN 1 failed to disinfect the stethoscope before or after use on Patient #8. RN 1 failed to perform hand hygiene after patient contact. The tablet used for patient documentation by RN 1 was provided to Patient #8 to sign without disinfecting before or after the patient signed.	N0470		
N0488	Q A and performance improvement CFR(s): 410 IAC 17-12-2(i) and G) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. G) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable	N0488	QA and performance improvement CONTINUED ON PAGE 4 OF 11	07.03.24

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N0488	Continued from page 3 based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to provide a fifteen-day notice before discharging a patient, affecting 1 of 2 discharged patient records reviewed. (Patient# 2) Findings include: A 05/2020 policy titled "Discharge" indicates the Patient, the patient's legal representative, or another individual responsible for the patient's care should be given a discharge notice at least fifteen calendar days before the services stop. A review of Patient #2's record, certification period 04/12/2023 to 06/08/2023, included a Visit Note Report dated 06/08/2023 visit type as RN Discharge from Agency. The record failed to evidence a 15-day discharge notice. During an interview on 05/30/2024 at 1:02 PM, the Administrator indicated she could not locate a 15-day notice in Patient #2's chart.	N0488	The Administrator is responsible for ensuring all patients are provided a fifteen-day notice of before discharging the patient. The Administrator in-serviced all clinical staff on Policy CC.011 Discharge. Specifically, the State requirement. "The patient, the patient's legal representative, or other individual responsible for the patient's care shall be given notice of discharge at least fifteen (15) calendar days before the services are stopped." The Administrator in-serviced all clinical staff on the 15-Day Discharge Notice form located in all patients home folders. The Administrator or designee will audit 100% of all pending discharges for 3 months to ensure the patient was given a discharge notice at least 15-days prior to planned discharge. Target threshold is 100%. Once threshold is met, the Administrator or designee will review 10% of discharges each quarter to ensure ongoing compliance with this requirement.	
N0522	Patient Care CFR(s):410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the agency failed to have a signed plan of care (POC) or a verbal POC order from the primary physician before providing services and treatments to patients, affecting 8 of 8 patient record reviews with the potential to affect all patient records. (Patient #1, #2, #3, #4, #5, #6, #7, #8)	N0522	Patient Care The Administrator is responsible for ensuring medical care follows a written medical plan of care established and periodically reviewed by the physician. The Administrator in-serviced all clinical staff on Policy CC.032 Plan of Care. Specifically, "The agency will develop and implement an individualized Plan of Care (POC) for each patient admitted to the agency. Clinical services are implemented in accordance with a POC established by a provider's written orders, when required by state/federal regulation." "4. If a provider orders services that cannot be completed until after an evaluation/comprehensive assessment, the provider is consulted to approve additions or modification to the original plan." CONTINUED ON PAGE 5 OF 11	07.03.24

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N0522	Continued from page 4 Findings included: 1. A revised 02/2022 policy titled "Plan of Care" indicated if a provider orders services that cannot be completed until after an evaluation/comprehensive assessment, the provider is consulted to approve additions and modifications to the original plan. 2. A 12/2019 policy titled "Physician Orders" indicated that Physician orders are required prior to care being initiated. All orders must have a physician date with the physician's signature, and verbal orders must be written, signed, and dated with a time stamp. A plan of care/treatment is a physician's order. 3. The record review for Patient #1, certification period 08/24/2023 to 10/19/2023, revealed that patient care was provided to Patient #1 without a verbal or physician-signed order on 08/24/2023. 4. The record review for Patient #2, certification period 04/12/2023 to 06/08/2023, revealed that patient care was provided to Patient #2 without a verbal or physician-signed order on 04/27/2023. 5. The record review for Patient #3, certification period 05/01/2024 to 06/29/2024, revealed that patient care was provided to Patient #3 without a verbal or physician-signed order on 05/06/2024 and 05/13/2024. 6. The record review for Patient #4, certification period 05/12/2024 to 07/10/2024, revealed that patient care was provided to Patient #4 without a verbal or physician-signed order on 05/14/2024, 05/17/2024, and 05/20/2024. 7. The record review for Patient #5, certification period 05/22/2024 to 07/20/2024, revealed that patient care was provided to Patient #5 without a verbal or physician-signed order on 05/30/2024. 8. The record review for Patient #6, certification period 05/22/2024 to 07/20/2024, revealed that patient care was provided to Patient #6 without a verbal or physician-signed order on 05/31/2024. 9. The record review for Patient #7, certification period 05/20/2024 to 07/18/2024, revealed that patient care was provided to Patient #7 without a verbal or physician-signed order on 05/23/2024 and 05/28/2024. During an interview on 05/30/2024 at 12:22 PM, the Administrator indicated that the verbal order date and	N0522	In addition: The Administrator in-serviced all clinical staff on Policy CC.031 Physician Provider Orders. Specifically, "2. Provider's orders are required prior to care being initiated. Provider orders may be signed by another provider who is authorized by the attending provider to care for his/her patient in his/her absence." "4. Verbal orders must be written, signed, and dated and timed that the order is received by the Registered Nurse (RN) or qualified therapist." The Administrator or designee will audit 100% of active patients' records for 3 months to ensure physician verbal order or a sign order is obtained prior to providing services or treatment to the patients. Target threshold is 100%. Once threshold is met, the Administrator or designee will review 10% of physician orders each quarter to ensure ongoing compliance with this requirement. CONTINUED ON PAGE 6 OF 11	

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N0522	Continued from page 5 time at the top of the POC are when the admission nurse received verbal orders from the physician for the POC. She indicated that the admission nurse should discuss visit frequency and education to be provided to the patient. The Administrator could not locate verbal order details in Patient #7's chart. 10. The record review for Patient #8, certification period 05/24/2024 to 07/22/2024, revealed that patient care was provided to Patient #8 without a verbal or physician-signed order on 05/31/2024. 11. During an interview on 05/30/2024 at 12:22 PM, the Administrator indicated she was not aware that the POC had to be signed before services could be provided and that a detailed verbal order was needed until the POC was signed. She indicated that there are no patient charts containing a written, detailed verbal order.	N0522		
N0524	Patient Care CFR(s): 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments.	N0524	Patient Care CONTINUED ON PAGE 7 OF 11	07.03.24

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N0524	Continued from page 6 (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record reviews, and interviews, the agency failed to ensure the Plan of Care (POC) specified mental orientation on 8 of 8 record reviews (Patient #1, #2, #3, #4, #5, #6, #7, #8) and the agency failed to include current medication and treatments on POC, affecting 2 of 2 patients with tube feed. (Patient #5, #7) Findings include: 1. A 02/2022 revised policy titled "Plan of care" indicated the contents of the patient's POC should include prescribed and over-the-counter (OTC) medications, mental and cognitive status, and pertinent clinical history. 2. During an observation on 05/30/2024 at 10:20 AM, Patient #5's caregiver provided a bolus feed through the patient's G-tube (a tube inserted through the belly that brings nutrition directly to the stomach) and discussed the patient's bowel regimen, including a suppository used every three days with RN 1. The agency failed to include G-tube care and suppository medication on the POC. 3. The record for Patient #1, certification period 08/24/2023 to 10/19/2023, included a POC that revealed the patient's mental status as "Oriented." The agency failed to specify the patient's orientation to person, place, and time on the POC. 4. The record for Patient #2, certification period 04/12/2023 to 06/08/2023, included a POC that revealed the patient's mental status as "Oriented; Forgetful." The agency failed to specify the patient's orientation to person, place, and time on the POC. 5. The record for Patient #3, certification period 05/01/2024 to 06/29/2024, included a POC that revealed the patient's mental status as "Oriented." The agency failed to specify the patient's orientation to person, place, and time on the POC.	N0524	The Administrator will be responsible for ensuring the Plan of Care includes the required elements to cover specified mental orientation and current medication and treatments. Administrator in-serviced all clinical staff on Policy CC.032 Plan of Care. Specifically, "5. The contents of the patient's POC may include, but are not limited to: "d. Prescribed and over-the-counter (OTC) Medications; "k. Mental and cognitive status"; and "t. Pertinent clinical history". Plans of Care updated for all current active patients. Administrator or designee will audit 100% of active patients' Plans of Care monthly for 3 months to ensure all required elements to cover specified mental orientation and current medication and treatments are included on the Plan of Care. Target threshold is 100%. Once threshold is met, the Administrator or designee will review 10% of Plans of Care each quarter to ensure ongoing compliance with this requirement. CONTINUED ON PAGE 8 OF 11	07.03.24

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N0524	Continued from page 7 6. The record for Patient #4, certification period 05/12/2024 to 07/10/2024, included a POC that revealed the patient's mental status as "Oriented." The agency failed to specify the patient's orientation to person, place, and time on the POC. 7. A review of Patient #5's rPOC for the certification period 05/22/2024 to 07/2024 failed to include Patient #5 having a G-tube; failed to include over the counter suppositories being used and tindicated the patient's mental status was "Lethargic". The agency failed to specify patients' orientation to person, place, and time; and failed to include G-tube care and suppository medication on the POC. During an interview on 05/30/2024 at 10:20 PM, Patient #5's caregiver indicated the patient was started on over-the-counter suppositories before starting care with the agency, and a G-tube was present before starting services with the agency. During an interview on 05/30/2024 at 1:15 PM, RN 1 indicated he was not aware of the suppository Patient #5's caregiver was using for the bowel regimen but was aware of the G-tube. During an interview on 05/30/2024 at 1:15 PM, the Administrator could not determine Patient #5's mental status. The Administrator expressed she did not expect RN 1's charting to be up to standard due to RN 1 starting with the agency in March 2024. 8. The record for Patient #6, certification period 05/22/2024 to 07/20/2024, included a POC that revealed the patient's mental status as "Oriented; Forgetful." The agency failed to specify the patient's orientation to person, place, and time on the POC. 9. The record for Patient #7, certification period 05/20/2024 to 07/18/2024, included a 05/20/2024 Visit Note Report that indicated the patient has a feeding tube. The POC failed to include the patients' tube feeding. The patient's mental status on POC was "Oriented." The agency failed to specify patients' orientation to person, place, and time on POC and failed to accurately document current treatments. 10. The record review for Patient #8, certification period 05/24/2024 to 07/22/2024, included a POC that revealed the patient's mental status as "Oriented; Forgetful." The agency failed to specify the patient's orientation to person, place, and time on the POC.	N0524	CONTINUED ON PAGE 9 OF 11	

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N0524	Continued from page 8 11. During an interview on 05/30/2024 at 1:15 PM, the Administrator indicated that the agency's documentation system does not have the options of person, place, or time, and there are no free text boxes. Therefore, no record will have this documentation. 12. During an interview on 05/30/2024 at 1:15 PM, RN 1 indicated he did not think G-tubes had to be included on the patient's POC if the agency was not providing care to it.	N0524		
N0532	Patient Care CFR(s): 410 IAC 17-13-1(d) Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to communicate changes found during home visits to physicians, affecting 2 of 3 home-visit patients. (Patient #6, #8) Findings include: 1. A 12/2019 revised policy titled "Physician Orders" indicated Orders are obtained, reviewed, and updated according to changes in the patient's physical and/or psychosocial status During an observation on 05/31/2024 at 1:03 PM, Patient #6 was found lying in bed, not able to perform ADLs independently, not able to roll over without assistance, refused to get out of bed due to pain, required assistance of two for personal care to be provided. 2. A review of Patient #6's record included a Client Coordination Note Report dated 06/01/2024, which indicates the Administrator did not report that the patient's status had changed from 05/22/2024 to 05/31/2024 and failed to alert the physician of the status change. During an interview on 06/03/2024 at 8:45 AM, the Administrator indicated that on 05/22/2024, Patient #6	N0532	Patient Care The Administrator will be responsible for ensuring patient's physician is notified of any changes in patient's condition. The Administrator in-serviced all clinical staff on Policy CC.031 Physician Provider Orders. Specifically, "1. Orders are obtained, reviewed and updated in accordance with laws, regulatory guidelines, Company policy, and as appropriate, according to: a. Changes in the patient's physical and/or psychosocial status;". The Administrator or designee will audit 100% of active medical records monthly for 3 months to ensure physician was notified of any changes in patient's condition and orders obtained. Target threshold is 100%. Once threshold is met, the Administrator or designee will review 10% of medical records each quarter to ensure ongoing compliance with this requirement. CONTINUED ON PAGE 10 OF 11	07.03.24

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N0532	Continued from page 9 was up walking, talking, and giving a tour of the home. The Administrator indicated that the patient's status changed from the date of admission on 05/22/2024 to the visit provided on 05/31/2024. 3. During an observation on 05/31/2024 at 3:00 PM, RN 1 asked Patient #8 if there had been new medication changes; Patient #8 indicated Hydralazine (used to treat high blood pressure) was changed from 1 tablet to 0.5 tablet. During an interview on 06/03/2024 at 8:45 AM, the Administrator reviewed the records of Patient #8, indicating 05/31/2024 home visit documentation was completed in the system and was not able to locate a physician order, a coordination note or documentation within the visit of the patient having a medication change. The Administrator indicated when medication changes are made, there should be a note placed in the chart, the physician should be contacted to confirm the medication change, and an order should be written.	N0532		
N0608	Clinical Records CFR(s): 410 IAC 17-15-1(a)(1-6) Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews, the agency failed to keep the required discharge summary	N0608	Clinical Records The Administrator will be responsible for ensuring the agency keeps the required discharge summary documentation in the patient's clinical record. The Administrator will educate the Medical Records Specialist on the process for ensuring discharge summaries are upload to the patient's medical record. The Administrator in-serviced all clinical staff on Discharge Policy CC.011. Specifically, "11. c. The clinician completes the Discharge-Transfer Summary Report at the time of discharge. The provider is sent a copy of the Discharge-Transfer Summary Report and a copy is kept in the permanent medical record. The Administrator or designee will review 100% of all transfer and discharges for at least 6 weeks. Target threshold is 100%. Once threshold is met, the Administrator or designee will review 10% of discharges each quarter to ensure ongoing compliance with this requirement.	07.03.24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24141521	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE HOME HEALTH	3135 EAST WABASH AVENUE , TERRE HAUTE, Indiana, 47803

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N0608	Continued from page 10 documentation in the patient's clinical records, affecting 2 of 2 discharged patient records reviewed. (Patient #1, #2) Findings include: 1. A 05/2020 revised policy titled "Discharge" indicated the clinician completes the Discharge Summary at the time of discharge; the provider must be notified of discharge and documentation must be maintained l the medical record that the provider was notified, and the clinician completes the discharge – transfer summary report at the time of discharge and a copy is kept in the permanent medical record. 2. A review of Patient #1's record, certification period 08/24/2023 to 10/19/2023, included a Visit Note Report dated 10/19/2023, visit type as Care Connections Discharge, indicating the patient was discharged from the agency on 10/19/2023. No documentation of the discharge summary was found in the chart. During an interview on 05/30/2024 at 12:56 PM, the Administrator indicated she was unable to locate the discharge summary in Patient #1's chart or verify that a discharge summary was sent to the physician. She indicated that the discharge summary would have been sent by fax through Forcura (a secure messaging system) and would not be part of the patient's medical record. 3. A review of Patient #2's record, certification period 04/12/2023 to 06/08/2023, included a Visit Note Report dated 06/08/2023 visit type as RN Discharge from Agency. No documentation of the discharge summary was found in the chart. During an interview on 05/30/2024 at 1:02 PM, the Administrator indicated she was unable to locate the discharge summary in Patient #2's chart or verify that a discharge summary was sent to the physician. The Administrator indicated that faxes are sent through Forcura, and that would be where the discharge summary could be found, but Forcura is not part of the patient's chart.	N0608		