STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K182	A. BUILDING B. WING	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABLE HANDS HOMECARE	3802 SOUTH ADAMS STREET, MARION, IN, 46953

(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 Date: May 21, 2025 Active Census: 58 At this Emergency Preparedness survey, Able Hands Homecare was not found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000		
E0013	Development of EP Policies and Procedures 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b),	E0013	The administrator has updated the emergency preparedness plan to include the individual policy and procedures related to hazards identified in the hazard risk assessment. The administrator and cm have in-serviced all staff on policies related to areas identified on the hazard risk assessment. The administrator will review policies,	2025-05-30

	§485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [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. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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 annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.		procedures and determine any needed updates as defined by the hazard risk assessment and emergency preparedness drills/exercises annually.	

	*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the home health agency failed to update the EP policies and procedures based on the hazard risk assessment for 1 of 1 agency. Findings include: 1. Review of the agency s EP plan failed to evidence policies and procedures related to the hazards identified on the Hazard Risk Assessment. 2. During an interview on 5/21/25 at 12:27 PM, the Administrator confirmed the EP plan did not include specific individual policies related to the hazard risk assessment findings.			
G0000	INITIAL COMMENTS This was a Post-Condition revisit for the home health recertification/complaint survey	G0000		

conducted on 4/10/25.

Survey Date: May 21, 2025

Three previously cited conditions were corrected. Thirty previously cited deficiencies were

Corrected and One previously cited deficiency was re-cited.

Based on the Condition-level deficiencies during the April 10, 2025 survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on April 10, 2025. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating a home health aide training, skills competency and/or competency evaluation program for a period of two years beginning April 10, 2025 and continuing through April 9, 2027.

<u>Abbreviations</u>
CM-Clinical Manager

EP-Emergency Preparedness

	HHA-Home Health Aide POC-Plan of Care SOC-Start of Care QR 5/27/25 A2			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge;	G0574	The CM has corrected the 3 deficient patient charts to reflect individualized patient goals. The CM has In-serviced all RN's when creating patient goals, goals must be individualized to the patient and be measurable. The CM and Alternate CM have audited 100% of active charts to ensure deficient practice has not occurred. The CM or the alternate CM will review all goals when creating plan of care to ensure deficient practice does not recur. The plan of care policy was updated to reflect measurable goals and the signed plan of care will be entered in the patients chart within 30 days of admission or recertification. The plan of care policy was also updated to reflect the 485/plan will be completed within 10 days of admission or recertification assessment.	2025-05-30

	(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. Based on record review and interview, the home health agency failed to ensure the POC included individualized patient-specific goals and measurable outcomes for 3 of 3 active records reviewed with HHA services (Patient #14, 15 and 17). Findings include: 1. The undated agency policy Plan of Care indicated the Plan of Care shall be completed in full to include treatment goals and the Plan of Care/485 will be developed following the initial assessment and will be developed with five (5) working days. 2. Patient #14 s clinical record included a POC for the certification period 5/07/25 to 7/05/25. The POC indicated the agency s goals for Patient #14 were Patient s personal care needs will be met; Target Date 7/5/2025; and Promote safe personal care and hygiene;			

	Target date 7/5/2025. The POC also evidenced a Goals/Outcomes Comments section which included Patient will have no ER visits or hospitalizations T/O Cert. Patient will have no falls T/O Cert. Patient will have no skin breakdown T/O Cert. Patient will maintain adequate hygiene T/O Cert. Patient will maintain current level of function with no decline T/O Cert. Patient will remain safe in home with agency assist. The POC failed to evidence the goals were individualized and measurable. During an interview on 5/21/25 at 1:50 PM, the Alternate CM relayed she did not enter the above goals on the POC. The goals were entered by the CM. The Alternate CM indicated she did not want to answer surveyor questions regarding clinical records created by the CM. During an interview on 5/21/25 at 3:09 PM, the CM relayed she felt the goals were measurable because the HHA completed a visit note for each visit. 3. Patient #15 s clinical record included a POC for the certification period 4/15/25 to			

	6/13/25. The Alternate CM completed a SOC comprehensive assessment on 4/15/25. The POC was created and signed by the CM on 4/24/25, nine days after the comprehensive assessment. The POC indicated the agency s goals for Patient #15 included but were not limited to Patient s personal care needs will be met; Target Date 6/13/2025; Promote safe personal care and hygiene; Target date 6/13/2025. The POC also evidenced a Goals/Outcomes Comments section which included Patient will have no ER visits or hospitalizations T/O Cert. Patient will have no falls T/O Cert. Patient will have no skin breakdown T/O Cert. Patient will maintain adequate hygiene T/O Cert. Patient will maintain current level of function with no decline T/O Cert. Patient will remain safe in home with agency assist. The POC failed to evidence the goals were individualized and measurable. The POC failed to evidence the goals were individualized and measurable. During an interview on 5/21/25 at 1:50 PM, the Alternate CM verified the POC was not			

	created within 5 days of SOC, relayed she did not enter the above goals on the POC The Alternate CM indicated she did not want to answer surveyor questions regarding clinical records created by the CM. During an interview on 5/21/25 at 3:09 PM, the CM relayed she felt the goals were measurable because the HHA completed a visit note for each visit. During an interview on 5/21/25 at 3:44 PM, the CM relayed the POC wasn t required to be completed within 5 days, that was only the assessment. After reviewing the POC policy, she agreed that the policy did state the POC must be completed within 5 days. She then stated the POC policy needed to be changed. 4. Patient #17 s clinical record included a POC for the certification period 4/15/25 to 6/13/25. The Alternate CM completed a SOC comprehensive assessment on 4/15/25. The POC was created and signed by the CM on 4/24/25, nine days after the comprehensive assessment. The POC Goals section was blank.			

	The POC also evidenced a Goals/Outcomes Comments section which included Patient will have no ER visits or hospitalizations T/O Cert. Patient will have no falls T/O Cert. Patient will have no skin breakdown T/O Cert. Patient will maintain adequate hygiene T/O Cert. Patient will maintain current level of function with no decline T/O Cert. Patient will remain safe in home with agency assist. The POC failed to evidence patient specific measurable goals. During an interview on 5/21/25 at 1:50 PM, the Alternate CM verified the POC was not created within 5 days of SOC and confirmed the POC for Patient #17 was missing patient-specific goals. During an interview on 5/21/25 at 3:44 PM, the CM relayed the POC wasn t required to be completed within 5 days, that was only the assessment. After reviewing the POC policy, she agreed that the policy did state the POC must be completed within 5 days. She then stated the POC policy needed to be changed.			

N0000	Initial Comments This revisit was for a State Re-Licensure survey of a Home Health Provider. Survey Date: May 21, 2025 12 Month Unduplicated Skilled Admissions: 6	N0000		

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
Traci	Hearn	6/9/2025 11:00:21 AM