DEPARTMENT OF HEALTH AND HUM	MAN SERVICES		FORM APPR
CENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 093
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>	COMPLETED
	15K153	B. WING	09/25/2020

2020 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7920 GEORGETOWN ROAD #600 AM - PM HOME HEALTH SERVICES LLC INDIANAPOLIS. IN 46268 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE E 0000 Bldg. 00 E 0000 An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102, for a home health agency. Facility #: 014070 Survey dates: 9-22, 9-23, 9-24, and 9-25-2020 Skilled Unduplicated Admissions in prior 12 months: Current Census: Skilled Services: 4 Unskilled: 51 Total: 55 E 0006 403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a) (1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), Bldg. 00 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) (1)-(2), 485.625(a)(1)-(2), 485.68(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)Plan Based on All Hazards Risk Assessment [(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:]

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K153	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/25/2020
	ROVIDER OR SUPPLIEF		7920 G	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD #600 IAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	· ·	nd include a documented, community-based risk ing an all-hazards			
	, ,	lies for addressing s identified by the risk			
	Emergency Plan. develop and main preparedness plan and updated at lead to the following: (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strateg	s at §483.73(a)(1):] The LTC facility must tain an emergency in that must be reviewed, ast annually. The plan must and include a documented, community-based risk ing an all-hazards ag missing residents. gies for addressing sidentified by the risk			
	Plan. The ICF/IID an emergency prebe reviewed, and years. The plan m (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strateg	_			
		§418.113(a)(2):] The Hospice must develop mergency preparedness			

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11/05/2020 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/25/2020 15K153 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7920 GEORGETOWN ROAD #600 AM - PM HOME HEALTH SERVICES LLC INDIANAPOLIS, IN 46268 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. E 0006 E0006 Based on record review and interview, the agency 10/26/2020 failed to develop and implement an all hazard AM PM DON and clinical staff approach to their emergency preparedness plan have developed and implemented that included emerging infectious disease and a communication plan to include a strategies for addressing the emergency events Chain of Command identified in their hazard vulnerability analysis for Communication Tree which 1 of 1 agency. identifies staff members responsible for the notification of Findings included: clients in the event of an emergency on the local, state, On 9-23-2020 at 12:45 p.m., review of provided and federal level. This process agency document titled: "Preparing for an includes utilization of Policy B-400 Emergency", failed to evidence the inclusion of "Home Care Emergency emerging infectious disease into their policy/plan Procedures" which classifies each clients level of priority to be On 9-23-2020 at 1:00 p.m., review of provided completed upon initiation of care. agency policy titled "Emergency Management AM PM DON has met with clinical Policy" evidenced a 20 item list of technological staff on 10/26/20 to update and events and a 14 item list of human events, inform them of their prioritized for probability, risk and preparedness responsibilities identified on the from the American Society for Healthcare Chain of Command Engineering and addressed by the agency as their Communication Tree. The hazard vulnerability analysis. This document **Emergency Management Policy** failed to evidence emerging infectious diseases will be updated to reflect these

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into the potential event list.

A review of the above provided documents failed

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changes by 10/26/20.

The Communication tree will be

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K153	(X2) MULTIPLE (A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/25/2020
	ROVIDER OR SUPPLIER HOME HEALTH SE		7920	T ADDRESS, CITY, STATE, ZIP COD GEORGETOWN ROAD #600 NAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	infectious diseases a	ncy included emerging as well as strategies for demergency events identified rability analysis.		reviewed and updated annuall reflect any changes in staff an specific staff responsibilities a warranted.	d/or
	Administrator and O of emerging infection plan and the lack of	30 p.m., the Alternate Owner acknowledged the lack ous disease in their emergency a strategies to address the d when queried, provided		The DON and/or designee will responsible for monitoring the corrective actions annually to ensure that this deficiency is corrected and will not recur.	
E 0021 Bldg. 00	[(b) Policies and p develop and imple preparedness policies on the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policies be reviewed and u years.] At a minim procedures must a (3) The procedure staff and patients are needed, in the interruption in servemergency. The literature of the procedure	for Follow up Staff/Pts. rocedures. The HHA must ment emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the can at paragraph (c) of this cies and procedures must updated at least every 2 um, the policies and caddress the following:] s to follow up with on-duty to determine services that revent that there is an vices during or due to an HHA must inform State and revended to the service of the servic			
	that they are unab Based on record rev failed to include pol state and local offic patients that they we		E 0021	E0021 AM PM DON and clinical staff revised and implemented AM Emergency Information folder "Preparing for an Emergency" document to include a process inform state and local officials	PM and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/25/2020 15K153 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7920 GEORGETOWN ROAD #600 AM - PM HOME HEALTH SERVICES LLC INDIANAPOLIS, IN 46268 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE any on-duty staff or patients in the On 9-23-2020 at 12:45 p.m., review of provided event that AM PM staff are unable

agency document titled: "Preparing for an Emergency", failed to evidence identification of state and/or local emergency officials and a plan or process to inform said officials if they were unable to contact staff and/or patients.

On 9-23-2020 at 1:00 p.m., review of provided agency policy titled "Emergency Management Policy", failed to evidence identification of state and/or local emergency officials and a plan or process to inform said officials if they were unable to contact staff and/or patients.

On 9-25-2020 at 2:30 p.m., the Alternate Administrator and Owner acknowledged the lack of process that includes the identification/list of local and/or state emergency officials to contact in an emergency, and when queried, provided nothing further.

to contact staff or patients during or due to an emergency. AM PM will also revise policy B-400 "Emergency Management Policy" to include a procedure for informing local and state officials for notification of inability to contact staff or clients in the event of an emergency by 12/04/20.

AM PM DON and clinical staff will update and utilize Policy B-400 "Home Care Emergency Procedures" (Document for SOC packet) and include level of priority for each client in Plan of care as notification to PCP of AM PM's emergency Plan for the client and will include brief explanation of what that level means for the client in the event of an emergency. Policy B-400 will include community officials and resources such as the local fire department, red cross, IMPD, and local church organizations for assistance when unable to contact staff or clients in the event of an emergency.

10% of charts will be audited quarterly, and the policy will be reviewed and revised as needed annually by the DON and/or designee to ensure compliance with these corrective actions.

The DON and/or designee will be responsible for monitoring these

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DEPARTMENT	T OF HEALTH AND HUN	MAN SERVICES				FOI	RM APPROVED
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K153	B. WI	NG		09/25/	/2020
				-			
NAME OF P	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD #600		
AM - PM	HOME HEALTH SE	ERVICES LLC		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					corrective actions annually to		

			,	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG		DATE
			corrective actions annually to	
			ensure that this deficiency is	
			corrected and will not recur.	
- 0004				
E 0024	403.748(b)(6), 416.54(b)(5), 418.113(b)(4),			
D	441.184(b)(6), 482.15(b)(6), 483.475(b)(6),			
Bldg. 00	483.73(b)(6), 484.102(b)(5), 485.625(b)(6),			
	485.68(b)(4), 485.727(b)(4), 485.920(b)(5),			
	491.12(b)(4), 494.62(b)(5)			
	Policies/Procedures-Volunteers and Staffing			
	[(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).] At a minimum, the			
	policies and procedures must address the			
	following:]			
	(6) [or (4), (5), or (7) as noted above] The use			
	of volunteers in an emergency or other			
	emergency staffing strategies, including the			
	process and role for integration of State and			
	Federally designated health care			
	professionals to address surge needs during			
	an emergency.			
	*IFor DNILICIo at \$402.749/b):1 Policios and			
	*[For RNHCIs at §403.748(b):] Policies and			
	procedures. (6) The use of volunteers in an			
	emergency and other emergency staffing			
	strategies to address surge needs during an			
	emergency.			
	*[For Hospice at §418.113(b):] Policies and			
	procedures. (4) The use of hospice			
	employees in an emergency and other			
	emergency staffing strategies, including the			
	amongonoy oldning ordioglos, moldanig the			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15K153	B. W	ING _		09/25	/2020
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			EORGETOWN ROAD #600		
ΔМ - РМ	HOME HEALTH SI	ERVICES I I C			IAPOLIS, IN 46268		
AIVI - I IVI		LITTIOLO LLO		INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 '	for integration of State and					
	Federally designa						
	professionals to a	ddress surge needs during					
	an emergency.						
		view and interview, the agency	E 0	024	E0024		12/04/2020
		ad solicited volunteers for			AM PM clinical staff will contact		
		saster or emergency, to include			local Pike Township Fire Dept		
		ntegration with health care			IMPD-West Side District, Red		
	l -	g the disaster/emergency for 1			Cross, Mt. Pleasant MBC, a lo		
	_	gency disaster preparedness			area hospital, and Coalition A		
	plan.				to solicit volunteers for service		
	E' 1' T 1 1 1				during a disaster or emergence	-	
	Findings Included:				including their roles for integra	ation	
	0 0 22 2020 4 12				with agency health care		
		2:45 p.m., review of provided			professionals during the		
		itled: Preparing for an to evidence the use of			disaster/emergency by		
	volunteers into their				10/27/2020.		
	volunteers into their	r policy/pian.			AM DM DON will undete the		
	On 0 23 2020 at 1:	00 p.m., review of provided			AM PM DON will update the document "Preparing for an		
		l "Emergency Management			Emergency" by 12/04/20 (pen	dina	
		vidence the use of volunteers			confirmation from all entities to	-	
	into their policy/pla				partner) to include these entiti		
	into their policy/pic	****			and develop and maintain a	03	
	On 9-25-2020 at 2:	30 p.m., the Alternate			partnership with agreeing		
		Owner acknowledged the lack			community organizations for		
		ir emergency plan and when			assistance in the event of a		
	queried, provided n	C			disaster or emergency. The		
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Emergency Management Police	CV	
					has been revised to include th	-	
					process of contacting and		
					maintaining a relationship with	1	
					those entities, local officials ar		
					organizations who agree to be		
					resource for our agency in the		
					event of a disaster or emerger	ncy.	
					HR and or designee will maint	tain	
					annual contact with the above		
					listed local officials/organization	ons	

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DEPARTMENT	OF HEALTH AND HUN	MAN SERVICES				FOI	RM APPROVED
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15K153	B. WI	NG		09/25/	/2020
	ROVIDER OR SUPPLIER	-		7920 GI	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD #600 APOLIS, IN 46268		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION

7 (10)	HOWE REALTH SERVICES LLC	II II II I	NAPOLIS, IN 40200	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
			to ensure continued availability for	
			assistance in the event of an	
			emergency or disaster.	
			The Emergency Management	
			Policy will be reviewed and revised	
			as needed annually by the DON	
			and/or designee to ensure	
			compliance with these corrective	
			actions.	
			The DON and/or designee will be	
			responsible for monitoring these	
			corrective actions annually to	
			ensure that this deficiency is	
			corrected and will not recur.	
E 0029	403.748(c), 416.54(c), 418.113(c),			
	441.184(c), 482.15(c), 483.475(c), 483.73(c),			
Bldg. 00	484.102(c), 485.625(c), 485.68(c),			
9	485.727(c), 485.920(c), 486.360(c),			
	491.12(c), 494.62(c)			
	Development of Communication Plan			
	(c) The [facility] must develop and maintain			
	an emergency preparedness communication			
	plan that complies with Federal, State and			
	local laws and must be reviewed and updated			
	at least every 2 years (annually for LTC).			
	Based on record review and interview, the agency	E 0029	E0029	10/23/2020
	failed to ensure the development and	2 002	AM PM DON and clinical staff	10/20/2020
	implementation of an emergency communication		has updated Policy B-400	
	plan for 1 of 1 agency.		Emergency Management policy to	
			include a specific emergency	
	Findings include:		communication plan for AM PM in	
	On 9-23-2020 at 12:45 p.m., review of provided		the event of a disaster or emergency. AM PM DON has	
	agency document titled: Preparing for an		held a meeting with all clinical	
	Emergency", failed to evidence the development		staff on 10/23/20 to review each	
	and implementation of an agency specific			
	and implementation of an agency specific		members role in the	

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STATEMENT OF DEFICIENCIES X1)	PROVIDER/SUPPLIER/CLIA					
	I RO VIDER SOTT EIER CEIN	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION IDE	NTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
15	5K153	B. WI	ING		09/25/	2020
NAME OF PROVIDER OR SUPPLIER AM - PM HOME HEALTH SERV (X4) ID SUMMARY STATE PREFIX (EACH DEFICIENCY MEGULATORY OR LSC communication plan for On 9-23-2020 at 1:00 p. agency policy titled "Enterpolicy", failed to evident implementation of an agroup communication plan for During an interview on Alternate Administrator the lack of an emergence of the complement of the lack of an emergence of the complement of the lack of an emergence of the complement of the lack of an emergence of the complement of the lack of an emergence of the complement of the lack of an emergence of the complement of the lack of an emergence of the complement of the lack of an emergence of the complement of the lack of an emergence of the complement of the lack of an emergence of the complement of the lack of an emergence of the complement of the lack of an emergence of the complement of the lack	TICES LLC TEMENT OF DEFICIENCIE MUST BE PRECEDED BY FULL EIDENTIFYING INFORMATION To use in an emergency. The development and gency specific To use in an emergency. 10. 11. 12. 13. 14. 15. 16. 16. 16. 16. 16. 16. 16	A. BU	JILDING ING STREET A 7920 G	ADDRESS, CITY, STATE, ZIP COD EORGETOWN ROAD #600 IAPOLIS, IN 46268 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Communication Plan. The Emergency Management Policy and Communication Pla will be reviewed and revised a needed annually to reflect any changes in staff and/or roles to the DON and/or designee to ensure compliance with these corrective actions. The DON and/or designee will responsible for monitoring the	COMPL 09/25/	ETED
additional information replan, the Alternate Admiprovided nothing further 403.748(c)(4)-(6), 416(4)-(6), 441.184(c)(4)-483.475(c)(4)-(6), 483.475(c)(4)-485.727(c)(4), 485.727(c)(4), 485.92494.62(c)(4)-(6) Methods for Sharing I [(c) The [facility] must an emergency prepare plan that complies wit local laws and must be at least every 2 years The communication per the following: (4) A method for sharing I	regarding a communication ininistrator and Owner r. 6.54(c)(4)-(6), 418.113(c) 6.6(), 482.15(c)(4)-(6), 6.73(c)(4)-(6), 484.102(c) 6.6(), 485.68(c)(4), 0(c)(4)-(6), 491.12(c)(4), Information Infor			1		

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(5) A means, in the event of an evacuation, to

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9HZQ11 Facility ID: 014070

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	OATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED	
		15K153	B. Wl	NG	_	09/25/	/2020	
NAME OF I	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP COD			
	PROVIDER OR SUPPLIEI				EORGETOWN ROAD #600			
AM - PM	HOME HEALTH S	ERVICES LLC		INDIAN	IAPOLIS, IN 46268			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE!		DATE	
	· ·	formation as permitted 4.510(b)(1)(ii). [This						
		equired for HHAs under						
	•	RFs under §485.68(c)]						
	3.0	3						
	(6) [(4) or (5)]A m	eans of providing information						
	_	condition and location of						
		e [facility's] care as						
	permitted under 4	5 CFR 164.510(b)(4).						
	*IFOR DNILLCIA at 5	§403.748(c):] (4) A method						
	for sharing inform							
		r patients under the RNHCl's						
		ry, with care providers to						
		inuity of care, based on the						
		atement made by the						
	patient or his or h	er legal representative.						
	*[For RHCs/FQH(Cs at §491.12(c):] (4) A						
	-	ng information about the						
	general condition	and location of patients						
		s care as permitted under 45						
	CFR 164.510(b)(4	•						
		view and interview, the facility	E 00)33	E0033		12/04/2020	
	•	method for sharing information nentation for patients under the			AM PM DON has revised the			
		g disaster relief purposes for 1			Patient Emergency Plan	ont		
	1 7	ency preparedness plan.			document and included a pation signature line to implement a pation			
	of Tagelley efficige	mey preparedness plan.			for sharing of information and	וומונ		
	Findings Included:				medical documentation for			
					patients under the agency's ca	are		
		2:45 p.m., review of provided			during a disaster and/or			
		itled: "Preparing for an			emergency. The "Patient			
		to evidence a plan for sharing			Emergency Plan" document w			
		medical documentation for			include local agencies (IMPD,			
	_	agency's care during a			dept, ambulance), PCP, hospi	tal		
	disaster/emergency	•			of patient's choice, and an			
	On 9-23-2020 of 1.	00 p.m., review of provided			emergency contact person the patient agrees may be contact			
		d "Emergency Management			and informed of health information			
	agone, pone, inte	- Lineigene, management				40011		

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EPARTMENT OF HEALTH AND HU	MAN SERVICES			FORM APPROVED
ENTERS FOR MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING <u>00</u>	COMPLETED
	15K153	B. WI	NG	09/25/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF FROVIDER OR SUPPLIER			7920 GEORGETOWN ROAD #600	
ANA DIALIONAL LIEALTILO			INDIANADOLIC IN 40000	

AM - PM	HOME HEALTH SERVICES LLC		INDIANAPOLIS, IN 46268			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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		
	Policy", failed to evidence a plan for sharing of information and medical documentation for patients under the agency's care during a disaster/emergency.		in the event of an emergency. B-400 Emergency Management Policy will be updated to reflect these changes by 10/27/20.			
	During an interview on 9-22-2020 at 12:30 p.m., the Alternate Administrator and Owner acknowledged the lack of policy/plan for the release of protected health information and sharing of patient information during an emergency. On 9-25-2020 at 2:30 p.m., when queried for additional information regarding release of protected health information and/or sharing of patient information, the Alternate Administrator and Owner provided nothing further.		The DON and clinical staff will update current client charts with the updated Emergency Plan Document form and obtain signatures from clients by 12/04/2020. The DON and/or designee will audit 10% of charts quarterly to ensure compliance with the updated form and its completion. The Emergency Management Policy will be reviewed and revised if necessary annually by the DON and/or designee to ensure compliance with these corrective actions. The DON and/or designee will be responsible for monitoring these corrective actions annually to ensure that this deficiency is corrected and will not recur.			
G 0000						
Bldg. 00	This visit was for a Federal Recertification, a Focused Infection Control, and a State Licensure survey of a home health agency. This survey was announced as partial extended on 9-25-2020, at 2:30 p.m.	G 0000				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ILDING	instruction 00	(X3) DATE COMPL 09/25/	ETED			
NAME OF PROVIDER OR SUPPLIER AM - PM HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP COD 7920 GEORGETOWN ROAD #600 INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	Survey dates: 9-22	9-23, 9-24, and 9-25-2020						
	Skilled Unduplicate months:	d Admissions in prior 12						
	Current Census:							
	4	Skilled Services:						
	51	Unskilled:						
	55	Total:						
	Record Review:							
	visit: 3	Record reviews with home						
	4	Record review only:						
	Acti	ve record reviews						
	Disc 2	harged record reviews						
	reviewed:	Total clinical records 7						
		reflect State Findings in 0 IAC 17. Refer to state form findings.						
	Quality Review cor	npleted on 10/5/2020 A4						

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15K153		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/25/2020	
	PROVIDER OR SUPPLIE		7920 0	ADDRESS, CITY, STATE, ZIP COD BEORGETOWN ROAD #600 NAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
G 0766 Bldg. 00	The HHA must m demonstrates that standard have be Based on record refailed to maintain a home health aide conskills check-off for health aide records. Findings Included: Review of provided aide, Employee C, patient contact of E evidence document competency testing a home health aide. Review of provided aide, Employee E, first patient contact evidence document competency testing a home health aide. On 9-25-2020 at 2: Administrator and	view and interview, the agency and provide documentation of competency evaluation and 2 (Employee C & E) of 3 home reviewed. If the personnel file for home health date of hire 10-1-2017 and first December 2018, failed to tation of home health aide and/or evaluation of skills for the determinant of the personnel file for home health date of hire 11-20-2017 and a tof December 2017, failed to tation of home health aide and/or evaluation of skills for	G 0766	G0766 AM PM DON and clinical staff update and individualize curred HHA Competency Checklist, completed upon hire by 12/04 AM PM HR will maintain documentation of home health aide competency evaluation, scheck-off, and HHA competer assessment exam in each employee file upon hire and pto initial patient contact. HR haudited employee files to enscompletion and inclusion of the Home health aide competence evaluation, skills check off, and HHA competency assessment exam in each employee file. DON and/or designee will ensmaintenance of employee file. DON and/or designee will ensmaintenance of employee file related to home health aide competency annually. AM PM DON, HR, and/or designee will complete new hour taudits upon hire of new employees prior to 1st patient contact to ensure completion employee file. HR will complet quarterly audits of 10% of Personnel files to monitor the corrective actions to ensure the deficiency is corrected and will and the corrective actions to ensure the deficiency is corrected and will and the corrective actions to ensure the deficiency is corrected and will and the corrective actions to ensure the deficiency is corrected and will and the corrective actions to ensure the deficiency is corrected and will and the corrective actions to ensure the deficiency is corrected and will and the corrective actions to ensure the deficiency is corrected and will and the corrective actions to ensure the deficiency is corrected and will and the corrective actions to ensure the deficiency is corrected and will and the corrective actions to ensure the deficiency is corrected and will and the corrective actions to ensure the deficiency is corrected and will and the corrective actions to ensure the deficiency is corrected and will and the correction and the cor	ent //20. h skills hocy rior as ure he y hid hit sure se his hocy // rior as his hocy hid

recur.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15K153 B. WING 09/25/2020 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7920 GEORGETOWN ROAD #600 AM - PM HOME HEALTH SERVICES LLC INDIANAPOLIS, IN 46268 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE G 0798 484.80(g)(1) Home health aide assignments and duties Bldg. 00 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). G0798 Based on record review and interview, the agency G 0798 12/04/2020 failed to ensure the Registered Nurse provided AM PM DON has educated current and complete written care instructions for clinical staff/RN to include in each the home health aide in 1 (Patient #5) of 2 aide aide plan of care current and home visits in a total sample of 7 clinical records. complete written care instructions for the home health aide to include Findings include: but not limited to, patient specific dietary/fluid restrictions and Review of Patient #5's clinical record evidenced a dialysis schedule including travel start of care of 10-31-19, a certification period of time. SN/RN will case conference 8-26-2020 to 10-24-2020, and a diagnosis of ESRD with primary care providers, (end stage renal disease or kidney failure) and on dialysis centers, patients private dialysis with treatments on Monday, Wednesday transportation and/or waiver & Friday and Diabetes (elevated blood sugar), services to coordinate care and with orders for home health aide services for 12 will document in patient chart hours per day, 7 days per week. under the Case Conference Summary document. The Aide plan of care or assignment sheet failed to evidence Patient #5's travel to dialysis, dialysis Skilled nursing will contact/case treatment length, days and times of treatment or conference with current patients' any dietary and/or fluid precautions/limitations PCP and/or dialysis centers for due to Patient #5's kidney failure. orders and review and update home health aid care plans to On 9-25-2020 at 2:30 p.m., the Alternate reflect specific dietary restrictions, Administrator, Owner and Patient #5's primary dialysis schedules, and

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PRINTED: 11/05/2020 FORM APPROVED OMB NO. 0938-039

	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K153	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/25/2020				
NAME OF PROVIDER OR SUPPLIER AM - PM HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP COD 7920 GEORGETOWN ROAD #600 INDIANAPOLIS, IN 46268					
SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE				
Registered Nurse, Employee D acknowledged the above findings and when queried, provided nothing further.			transportation arrangements applicable.	s if				
17-14-1(m)			DON and/or designee will complete quarterly charts audits on 10% of all charts monitor these corrective actions: dietary/fluid restrictions specific to eac client and care coordinatio with dialysis centers, other agencies involved, and transportation arrangement included in plan of care. DON and/or designee will be responsible for monitoring the corrective actions annually the ensure that this deficiency is corrected and will not recur.	h on r ots e nese o				
		N 0000						
home health agency Facility #: 014070 Survey dates: 9-22, Skilled Unduplicate months: Current Census:	, 9-23, 9-24, and 9-25-2020							
I	PROVIDER OR SUPPLIER HOME HEALTH SE SUMMARY: (EACH DEFICIEN REGULATORY OR Registered Nurse, E above findings and nothing further. 17-14-1(m) This visit was for a home health agency Facility #: 014070 Survey dates: 9-22, Skilled Unduplicate months:	DENTIFICATION NUMBER 15K153 PROVIDER OR SUPPLIER HOME HEALTH SERVICES LLC SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Registered Nurse, Employee D acknowledged the above findings and when queried, provided nothing further. 17-14-1(m) This visit was for a State Licensure survey of a home health agency. Facility #: 014070 Survey dates: 9-22, 9-23, 9-24, and 9-25-2020 Skilled Unduplicated Admissions in prior 12 months: 4 Current Census: Skilled Services:	OF CORRECTION IDENTIFICATION NUMBER 15K153 PROVIDER OR SUPPLIER HOME HEALTH SERVICES LLC SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Registered Nurse, Employee D acknowledged the above findings and when queried, provided nothing further. 17-14-1(m) N 0000 This visit was for a State Licensure survey of a home health agency. Facility #: 014070 Survey dates: 9-22, 9-23, 9-24, and 9-25-2020 Skilled Unduplicated Admissions in prior 12 months: 4 Current Census: Skilled Services:	DENTIFICATION NUMBER 15K153 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 7920 GEORGETOWN ROAD #600 INDIANAPOLIS, IN 46268 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DEINTIFITYIS INTORRAMITION Registered Nurse, Employee D acknowledged the above findings and when queried, provided nothing further. 17-14-1(m) DON and/or designee will complete quarterly charts audits on 10% of all charts monitor these corrective actions: dietary/fluid restrictions specific to eac client and care coordination with dialysis centers, other agencies involved, and transportation arrangement included in plan of care. DON and/or designee will be responsible for monitoring the responsible for monitoring the corrective actions annually the ensure that this deficiency is corrected and will not recur. N 0000 This visit was for a State Licensure survey of a home health agency. Facility #: 014070 Survey dates: 9-22, 9-23, 9-24, and 9-25-2020 Skilled Unduplicated Admissions in prior 12 months: 4 Current Census: Skilled Services:				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
15K153		15K153	B. WII	NG		09/25/	2020
NAME OF PROVIDER OR SUPPLIER AM - PM HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP COD 7920 GEORGETOWN ROAD #600 INDIANAPOLIS, IN 46268				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTI		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CED TO THE APPROPRIATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	51	Unskilled:					
	55	Total:					
	Record Review:						
	visit: 3	Record reviews with home					
	4	Record review only:					
	Activ	ve record reviews					
	Discharged record reviews 2						
	reviewed:	Total clinical records 7					
N 0460	410 IAC 17-12-1(g	•					
Bldg. 00	records of the sup under subsection ((1) Be kept currer (2) Include a copy (A) Limited crimin 16-27-2. (B) Nursing licens (C) Annual perfor (D) Documentation Performance evaluations subsection must be	nagement As follows, personnel ervising nurse, appointed (d) of this rule, shall: nt. v of the following: nal history pursuant to IC					

State Form Event ID: 9HZQ11 Facility ID: 014070 If continuation sheet Page 16 of 19

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
15K153		B. WING			09/25/2020		
				CTREET	A DDDEGG CITY CTATE ZID COD		
NAME OF I	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
A14 D14	LIONAE LIENT TULO	EDV40E0 LL 0			EORGETOWN ROAD #600		
AM - PM HOME HEALTH SERVICES LLC				INDIAN	IAPOLIS, IN 46268		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DEOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)	16	DATE
	Based on record rev	view and interview, the agency	N 0	460	N0460		11/07/2020
	failed to ensure pro	vide personnel files were			AM-PM Home Health Services	3	
	_	te in relation to having			Human Resource has reviewe	d	
	-	an employee signed a job			employee personnel files and		
		imployee C, D, & E) of 6			ensured that all employee files	;	
		ewed; failed to ensure			contain the appropriate job		
	-	rientation to their position in			descriptions signed by the		
		for 3 (Employee C, D, & E) of 6			employee. AM PM HR and DC)N	
	_	ewed; failed to evidence a			has reviewed job descriptions		
	-	ation for the most recent annual			staff to ensure they understan		
	-	3 (Employee C, D, & E) of 6			their job description prior to		
	employees.	(2mple) 00 0, 2, 00 2) 01 0			signing the form.		
	omprojees.						
	Findings included:				AM-PM Home Health Services	,	
	i maings included.			Human Resources ha			
	Review of Home H	ealth Aide, Employee C's		implemented 180 day perform		ance	
		ate of hire 10-1-2017, failed to		evaluations for all employee			
	evidence the presence of a signed Home Health				have been employed for 180 c		
	-	n, orientation to the home			and has revised AM PM policion		
		, and a performance evaluation		D-260 to reflect this require			
	_	annual appraisal period.			2 200 to romost time requirement		
					AM PM HR and DON will ensu	ıre	
	Review of Register	ed Nurse, Employee D's	each employee has complete				
		ate of hire 3-15-2019, failed to		orientation checklist and include			
	•	ace of a signed Registered			their employee files. AM PM D		
	-	on, orientation to the			will implement and create		
		sition, and a performance		separate orientation che			
		nost recent annual appraisal			1 ·		
	period.	nost recent annual appraisar			specific to nursing and HHA by 11/07/2020.		
	periou.				11/07/2020.		
	Review of Home H	ealth Aide, Employee E's			HR will do new hire chart audi	te	
	personnel record, date of hire 11-20-17, failed to evidence the presence of a signed Home Health				upon hire of new employees prior		
	Aide job description, orientation to the Home				to 1st patient contact to ensure		
	* *				completion of employee file. HR		
	Health Aide position, and a performance evaluation for the most recent annual appraisal				will also perform 10% of personnel file audits monthly.		
	period.	nost recent annual appraisar			inc addits monthly.		
	periou.				AM PM DON and HR will		
	On 9-25-2020 at 20	30 p.m., the Alternate			-		
					coordinate together and take		
	Administrator and Owner acknowledged the				responsibility to monitor these		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
		15K153	B. W	B. WING			09/25/2020	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	8			EORGETOWN ROAD #600			
AM DM	UOME HEVLTH SE	EDVICES LLC			APOLIS, IN 46268			
AIVI - PIVI	HOME HEALTH SE	ERVICES LLC		INDIAN	APOLIS, IN 40208			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTIO			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	above findings and	when queried, provided			corrective actions annually to			
	nothing further.			ensure that this deficiency is				
					corrected and will not recur.			
N 0488	410 IAC 17-12-2(i							
	Q A and performa	•						
Bldg. 00	• • • • • • • • • • • • • • • • • • • •	A home health agency						
	·	implement a policy						
		of discharge of service to						
		tient's legal representative,						
		responsible for the patient's						
		n (15) calendar days before						
	the services are st	topped.						
) day period described in						
	• • •	nis rule does not apply in						
	the following circu							
	• •	afety, and/or welfare of the						
		cy's employees would be at						
	-	nificant risk if the home						
		tinued to provide services						
	to the patient.							
	. ,	fuses the home health						
	agency's services.							
		services are no longer						
	reimbursable base	• •						
		quirements and the home						
	health agency info	· · · · · · · · · · · · · · · · · · ·						
	-	ces to assist the patient						
	following discharg							
		longer meets applicable						
	regulatory criteria,	and the home health						
	•	e patient of community						
		e patient of community at the patient following						
	discharge.	ine patient ionowing						
		view and interview, the agency	N 0	100	N-0488		10/23/2020	
		d implement a policy for a 15	IN U	+00	Director of Nursing (DON) has		10/23/2020	
	-	iding patient discharge for 1 of			updated Policy C-500 "Client			
		otential to impact all 55 agency			Discharge Process" to reflect t	he		
	r agency with the p	otential to impact all 33 agency			Discharge Frocess to reflect t	IIC		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
		IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPLETED		
15K153			B. WING 09/25/2020					
NAME OF I	PROVIDER OR SUPPLIER	-	STREET ADDRESS, CITY, STATE, ZIP COD					
					EORGETOWN ROAD #600			
AM - PM	HOME HEALTH SE	ERVICES LLC		INDIAN	APOLIS, IN 46268			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		E COMPI	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	patients.				15 day notification of impendir	ng		
					patient discharge (10/23/20).			
	Findings included:				Nurses will discontinue the five (5)			
					day notification of impending			
		ed agency policy titled "Client			discharge immediately and be	•		
		stated " clients are told in a		using the updated policy attached				
	timely manner of the need to plan for discharge,			(10/23/20). DON held in-service				
	but at least five (5) calendar days before services				with RN case managers to			
	are stopped"				educate on policy change and requirements (10/23/20).			
	On 9-25-2020 at 2:3	30 p.m., the Alternate			requirements (10/23/20).			
		Owner acknowledged the			Going forward, 100% of all			
		day notice of discharge and			discharged clients charts will be			
		ding the requirement of a 15		audited by DON or designee for				
		arge, provided nothing further.		one quarter for evidence that a 15				
	ĺ	871 8			day notice of impending patier			
					discharge is given as applicab			
					Going forward, 10% of all			
					discharged clients charts will b	е		
					audited quarterly for complian			
					with this corrective action.			
					AM PM DON or designee will	ho		
					responsible for monitoring the			
					corrective actions quarterly to	30		
					ensure that this deficiency is			
					corrected and will not recur.			

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