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	15K124	A. BUILDING _____ B. WING _____	08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AM HOME HEALTH CARE	3601 HOBSON ROAD, SUITE 104 FORT WAYNE, IN 46815

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G 000	INITIAL COMMENTS This visit was for a Federal home health Recertification and State Re-licensure survey Survey Dates: August 2, 3, 4, 5, and 6, 2021 Partially Extended on August 5, 2021 at 1:15 PM Facility number: 013209 Provider number: 15K124 Current Census: 134 Unduplicated Census last 12 months: 148 This deficiency reflects State and Federal findings cited in accordance with 410 IAC 17.	G 000		
G 574	Quality review completed 8/19/21 by Area 2 Plan of care must include the following CFR(s): 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;	G 574		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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G 574	Continued From page 1 (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure patients' plan of care included (but not limited to) all pertinent diagnoses, all medications and treatments, and measurable outcomes for 5 of 7 records reviewed (#1, 2, 3, 4, 5). Findings include: 1. Review of an agency policy dated 2016, titled "2.8 Care Plan" stated " ... steps to be taken in developing the care plan ... collection of baseline data including all pertinent diagnoses ... establishment ... provision of services which lists ... medication ... based upon the goals to be achieved, what actions must be taken to achieve them ... determination of the goals to be achieved ...." 2. Review of an agency job description dated 2016, titled "Title of Position: Registered Nurse" stated " ... responsibilities ... participates in the development and periodic revision of the	G 574		

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physician's Plan of Treatment and processes change orders as needed ...."

3. Clinical record review was completed on 8/2/2021 for patient #1, start of care 4/30/2019, certification period 6/18/2021 - 8/16/2021, with a primary diagnosis of essential hypertension (high blood pressure). An agency document titled "Home Health Plan of Care & Certification" dated 6/14/2021 by RN D and dated 6/16/2021 by MD (physician) A. This agency document stated " ... goal ... patient's pain will be within acceptable levels for patient within cert [certification] period ...." The plan of care failed to evidence a measurable goal.

During an interview on 8/3/2021 at 9:35 AM, assistant director of nursing, RN C indicated the acceptable level for pain for patient is found in the certification note and visit note (not on the plan of care).

4. Clinical record review was completed on 8/2/2021 for patient #2, start of care 10/18/2019, certification period 6/9/2021 - 8/7/2021, with a primary diagnosis of essential hypertension, and other diagnoses (but not limited to) asthma, gastro-esophageal reflux disease (heartburn), vitamin D deficiency, constipation, and mixed hyperlipidemia (high cholesterol). An agency document titled "Home Health Plan of Care & Certification" dated 6/4/2021 by RN D and dated 6/8/2021 by MD A. This agency document stated " ... medications ... Tradjenta oral tablet [diabetic medication] ... ER/Hospitalization Re-Admission Risk Factors and Interventions ... DM [diabetes] type 2 ... skilled nursing orders ... prn BS [blood sugar] checks for signs/symptoms of hypo/hyperglycemia [low or high blood sugar] ...

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goal ... patient will notify home health company immediately of blood sugar > [greater than] 350 or < [less than] 70 ...." The plan of care failed to evidence the pertinent diagnosis of diabetes.

During an interview on 8/3/2021 at 1:00 PM, director of nursing, RN B indicated diabetes should be included as a pertinent diagnosis in the plan of care.

5. Clinical record review was completed on 8/4/2021 for patient #3, start of care 12/17/2018, certification period 4/5/2021 - 6/3/2021, with a primary diagnosis essential hypertension and other diagnoses (but not limited to) monoplegia of lower limb (paralysis of one leg), osteoporosis (bones become brittle), gastro-esophageal reflux disease, vitamin D deficiency and joint pain. An agency document titled "Home Health Plan of Care & Certification" dated 3/31/2021 by RN O and dated 4/6/2021 by MD A. This agency document stated " ... medications ... Tradjenta oral tablet [diabetic medication] Supplies ... glucometer [measures blood sugar] ... ER/Hospitalization Re-Admission Risk Factors and Interventions ... DM [diabetes] ... skilled nursing orders ... prn BS [blood sugar] checks for signs/symptoms of hypo/hyperglycemia [low or high blood sugar] ...." The document also stated " ... goal ... patient's pain will be within acceptable levels for patient within cert period ...." The plan of care failed to evidence the pertinent diagnosis of diabetes and failed to evidence a measurable goal.

6. Clinical record review was completed on 8/3/2021 for patient #4, start of care 9/18/2017, certification period 6/29/2021 - 8/27/2021, with a primary diagnosis anxiety disorder and other

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diagnoses (but not limited to) auditory hallucinations (hearing voices), major depressive disorder, essential hypertension, chronic kidney disease and osteoarthritis (joint pain). An agency document titled "Home Health Plan of Care & Certification" dated 7/26/2021 by RN P and dated 6/29/2021 by MD A. This agency document stated " ... medications ... Januvia oral tablet ... diabetic agent ... safety measures ... diabetic precautions ... ER/Hospitalization Re-Admission Risk Factors and Interventions ... DM [diabetes] ...." The document also stated " ... goal ... patient will have better coping behavior evidenced by verbalization and ability to maintain within cert [certification] period ...." The plan of care failed to evidence the pertinent diagnosis of diabetes and failed to evidence a measurable goal.

7. Clinical record review was completed on 8/4/2021 for patient #5, start of care 3/18/2014, certification period 6/9/2021 - 8/7/2021, with a primary diagnosis fracture of neck of right femur (hip fracture). A document titled "After Visit Summary" dated 6/20/2021 by Hospital B stated " ... your medications have changed ... start taking ... prednisone [decreases inflammation] 20 mg tablet ... take 2 tablets by mouth daily for 5 days ...." An agency document titled Patient Communication Log dated 6/21/2021 by director of nursing, RN B stated " ... paperwork from Hospital stated DX [diagnosis] was strain of right ankle ... new orders given for Prednisone ...." An agency document titled "Skilled Nursing Visit Note" dated 6/22/2021 by RN G stated " ... pain management intervention ... prednisone helps ...." The plan of care failed to evidence the new diagnosis of strain of right ankle and failed to evidence the medication prednisone.

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G 574	Continued From page 5 During an interview on 8/4/2021 at 3:00 PM, director of nursing, RN B indicated the medication should be in the medication profile and diagnosis should be documented in orders. 17-13-1 (a)(1)(C) 17-13-1 (a)(1)(D)(ix)	G 574		
G 682	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure all staff followed standard precautions and infection control for 3 of 3 home visits observed (#1, 2, 4). Findings include: 1. Review of an undated agency policy titled "2.79 Bag Technique" stated " ... inside of nursing bag ... never enter without washing/sanitizing hands ...." 2. Review of an undated agency document titled "Bag Technique" stated " ... remove the supplies from bag and place them on a clean dry surface or a surface barrier as needed ... do not reenter the bag with gloves on ... remove the gloves if worn, perform hand hygiene, and then reenter the bag ...." 3. Review of an agency policy dated 2016, titled "2.80 Hand Washing Policy - In Patient's Homes"	G 682		

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stated " ... alcohol-based hand sanitizer is preferred ... before and after caring for clients ... between tasks on the same client ... after removing gloves ... after touching objects that are potentially contaminated ...."

4. A home observation visit was conducted with RN D on 8/2/2021 at 12:15 PM, with patient #1. RN D was observed applying hand sanitizer and gloves, checked vital signs, hand grasps, and palpated (examined by touch) bilateral pedal (right and left top of foot) pulses, and refilled medication box. RN D failed to remove soiled gloves, perform hand hygiene (wash hands with soap and water or with hand sanitizer) and apply clean gloves prior to filling medication box.

5. A home observation visit was conducted with RN G on 8/3/2021 at 10:55 AM, with patient #4. RN G was observed wearing gloves when exiting car and entering home of patient #4. RN G removed papers from folder and filled medication box, then removed soiled gloves having worn since exiting car. Removed thermometer and blood pressure cuff from nursing bag and placed on coffee table. Applied clean gloves, checked blood pressure and oxygen level. RN D failed to remove soiled gloves upon entering home, perform hand hygiene and apply clean gloves prior to filling medication box. RN G failed to perform hand hygiene prior to entering nurse bag and failed to place equipment on a barrier.

6. A home observation visit was conducted with RN I on 8/3/2021 at 11:55 AM, with patient #2. RN I was observed wearing gloves when exiting car and entering home of patient #2. RN I removed scale from nursing bag and weighed patient, placed sanitizing wipe on scale, placed

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G 682	Continued From page 7 scale in plastic bag, and placed plastic bag into nursing bag. RN I removed soiled gloves, applied clean gloves, and completed physical assessment of patient #2. RN I failed to remove soiled gloves upon entering home, perform hand hygiene and apply clean gloves prior to removing scale from nursing bag. RN I failed to clean scale before placing in plastic bag and placing in nursing bag and failed to perform hand hygiene after removing soiled gloves and before applying clean gloves. 7. During an interview on 8/3/2021 at 1:00 PM, when asked if the agency would expect a glove change and hand hygiene after physical assessment of patient and before filling a medication box, administrator A indicated yes. 8. During an interview on 8/4/2021 at 3:00 pm, when asked if the agency would expect an employee to wear gloves from their cars into a patient home and perform physical assessment without removing soiled gloves, administrator A indicated no. When asked if the agency would expect an employee to remove soiled gloves, apply hand sanitizer and apply clean gloves after performing physical assessment and before refilling medication box, administrator A indicated yes.	G 682		
G 768	17-12-1(m) Competency evaluation CFR(s): 484.80(c)(1)(2)(3) Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation	G 768		

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program as described in this section.

(1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation.

(2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section.

(3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate.
This STANDARD is not met as evidenced by:
Based on record review and interview, the agency failed to ensure the home health aide competency included the subject area of recognizing and reporting changes in skin condition for 4 of 4 employee files reviewed (Home Health Aide J, K, M, N).

Findings include:

1. Review of an agency document dated 12/29/2017 titled "Home Health Aide Competency Checklist" which is used for home health aide competency checkoffs, failed to evidence the subject area, recognizing and reporting changes in skin condition.

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G 768	Continued From page 9 2. Review of agency document dated 3/20/2020 titled "Home Health Aide Competency" completed for HHA (home health aide) N, failed to evidence the subject area, recognizing and reporting changes in skin condition. Review of agency document dated 4/27/2020 titled "Home Health Aide Competency" completed for HHA M, failed to evidence the subject area, recognizing and reporting changes in skin condition. 3. Review of agency document dated 9/4/2020 titled "Home Health Aide Competency" completed for HHA J, failed to evidence the subject area, recognizing and reporting changes in skin condition. 4. Review of agency document dated 11/17/2020 titled "Home Health Aide Competency" completed for HHA K, failed to evidence the subject area, recognizing and reporting changes in skin condition. 5. During an interview on 8/6/2021 at 11:05 AM, when queried if the Home Health Aide Competency form included the subject area, recognizing and reporting changes in skin condition, the administrator A indicated it did not.	G 768		
G 798	Home health aide assignments and duties CFR(s): 484.80(g)(1) 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	G 798		

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professional (that is, physical therapist, speech-language pathologist, or occupational therapist).
This STANDARD is not met as evidenced by:
Based on record review and interview, the agency failed to ensure the home health aide care plan was specific to the needs of the patient for 1 of 5 records reviewed who received home health aide services (#1).

Findings include:

1. Review of an agency policy dated 2016, titled "2.52 Home Health Aide Service" stated " ... professional staff responsibilities ... coordinating nurse ... is responsible ... determining individual patient needs ... providing direction ... to the Aide [home health aide] ...."

2. Clinical record review was completed on 8/2/2021 for patient #1, start of care 4/30/2019, certification period 6/18/2021 - 8/16/2021, with a primary diagnosis of essential hypertension (high blood pressure). An agency document titled "Home Health Plan of Care & Certification" dated 6/14/2021 and signed by RN D, dated 6/16/2021 and signed by MD A. This agency document stated " ... order ... home health aides ... are to call the office and speak with the nurse if their patient is diabetic and states sugars are high or low or have a general complaint of headache, dizziness, warm flushes, sweating without exertion, or other s/sx [signs/symptoms] of high or low blood sugars ...."

Clinical record review evidenced a document titled "Aide Plan of Care" dated 6/18/2021, signed by RN D. The document, stated "parameters to notify case manager [register nurse] ... other:

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G 798	Continued From page 11 blood sugar >350 or <70 ...." The home health aide care plan failed to indicate specific instructions of signs and symptoms of high and low blood sugar the home health aide is to report to a nurse. During an interview on 8/3/2021 at 9:35 AM, when queried how the home health aide knew the signs and symptoms of low and high blood sugar to call to a nurse, administrator A indicated blood sugar information is included in the home health aide training. Queried whether this information would be found in the home health aide plan of care, administrator A indicated it was not. 17-13-2 (a)	G 798		
G 800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the home health aide followed the plan of care for 5 of 5 records reviewed that were assigned home health aides (#1, 4, 5, 6, 7). Findings include: 1. Review of an agency policy dated 2016, titled "2.52 Home Health Aide Service" stated " ... an aide never decides which patient care procedures	G 800		

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G 800	Continued From page 12 ... she/he will perform ... an aide performs only those activities which have been assigned by a nurse ...." 2. Clinical record review was completed on 8/2/2021 for patient #1, start of care 4/30/2019, certification period 6/18/2021 - 8/16/2021, with a primary diagnosis of essential hypertension (high blood pressure). An agency document titled "Aide Plan of Care" dated 6/18/2021, signed by RN D. The document stated " ... bathing ... shower ... each visit ...." Clinical record review evidenced agency documents titled "HHA [home health aide] Weekly Visit Record" dated 6/21/2021 - 7/31/2021 for 30 visits, signed by HHA Q. The agency documents stated " ... bathing ... tub bath/shower ...." The HHA documentation identified the completed task as tub bath/shower. The home health aide documentation failed to identify the specific bathing task provided. 3. Clinical record review was completed on 8/3/2021 for patient #4, start of care 9/18/2017, certification period 6/29/2021 - 8/27/2021, with a primary diagnosis anxiety disorder. An agency document titled "Aide Plan of Care" dated 7/9/2021, signed by administrator A. This document stated " ... bathing ... shower ... each visit ...." Clinical record review evidenced agency documents titles "HHA Weekly Visit Record" dated 7/12/2021 - 7/24/2021 for 10 visits, signed by HHA K. These agency documents stated " ... bathing ... tub bath/shower ...." The HHA documentation identified the completed task as tub bath/shower. The home health aide	G 800		

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documentation failed to identify the specific bathing task provided.

4. Clinical record review was completed on 8/4/2021 for patient #5, start of care 3/18/2014, certification period 6/9/2021 - 8/7/2021, with a primary diagnosis of fracture neck of right femur (hip fracture). An agency document titled "Aide Plan of Care" dated 6/8/2021, signed by RN I. This document stated " ... bathing ... shower ... each visit ...."

Clinical record review evidenced agency documents titled "HHA Weekly Visit Record" dated 6/20/2021 - 7/24/2021 for 28 visits, signed by HHA R. These agency documents stated " ... bathing ... tub bath/shower ...." The HHA documentation identified the completed task as tub bath/shower. The home health aide documentation failed to identify the specific bathing task provided.

5. Clinical record review was completed on 8/4/2021 for patient #6, start of care 6/11/2016, certification period 7/15/2021 - 9/12/2021, with a primary diagnosis of chronic obstructive pulmonary disease. An agency document titled "Aide Plan of Care" dated 7/13/2021, signed by RN O. This document stated " ... bathing ... shower ... each visit ...."

Clinical record review evidenced agency documents titled "HHA Weekly Visit Record" dated 7/12/2021 - 7/30/2021 for 15 visits, signed by HHA S. These agency documents stated " ... bathing ... tub bath/shower ...." The HHA documentation identified the completed task as tub bath/shower. The home health aide documentation failed to identify the specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K124	A. BUILDING _____ B. WING _____	08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AM HOME HEALTH CARE	**3601 HOBSON ROAD, SUITE 104 FORT WAYNE, IN 46815**

(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
G 800	Continued From page 14 bathing task provided. 6. Clinical record review was completed on 8/5/2021 for patient #7, start of care 6/8/2018, certification periods 3/24/2021 - 5/22/2021 and 5/23/2021 - 7/21/2021, with a primary diagnosis diabetes. An agency document titled "Aide Plan of Care" dated 5/18/2021, signed by RN O. This document stated " ... bathing ... shower ... each visit ... or tub bath per pt [patient] request ...." Clinical record review evidenced agency documents titled "HHA Weekly Visit Record" dated 3/24/2021 - 5/14/2021 for 35 visits, signed by HHA T. These agency documents stated " ... bathing ... tub bath/shower ...." The HHA documentation identified the completed task as tub bath/shower. The home health aide documentation failed to identify the specific bathing task provided. 7. During an interview on 8/5/2021 at 9:00 AM, when asked if documentation should identify the type of bath provided, administrator A indicated yes, it should have.	G 800		