

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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 0000  Bldg. 00	<p>This was a home health agency federal recertification survey. This was a partial extended survey.</p> <p>Survey Dates: 5/19/2015 through 5/21/2015</p> <p>Facility Number: IN012094</p> <p>Medicaid Provider ID: 200947690</p> <p>Census Service Type: Skilled: 141 Home Health Aide Only: 34 Personal Services: 5 Total: 180</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>QR: JE 5/28/15</p>	G 0000		
G 0134  Bldg. 00	<p>484.14(c) ADMINISTRATOR</p> <p>The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures</p>			

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

TITLE

(X6) DATE

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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
	<p>adequate staff education and evaluations. Based on employee record and agency policy review and interview, the administrator failed to ensure staff evaluations were completed for 2014 for 2 of 8 employee records reviewed ( employees B and D).</p> <p>Findings:</p> <p>1) Employee record B, a registered nurse, date of hire 7/12/ 2013, failed to evidence an annual evaluation of the employee's performance for 2014.</p> <p>2) Employee record D, a physical therapist, date of hire 11/28/09, failed to evidence an annual evaluation of the employee's performance for 2014.</p> <p>3) An undated agency policy titled, Performance Evaluations states, "A competency based performance evaluation will be conducted for all employees every 12 months of employment."</p> <p>4) In an interview with employee I, the agency's administrator, on 5/21/2015 at 12:25 PM, the administrator acknowledged that no performance evaluations had been completed for employees B and D for 2014.</p>	G 0134	<p><b>G 134</b></p> <p>What action will we take to correct the deficiency cited? The Administrator or designee will compile a tracking system to follow the annual employee evaluation due date. Who is responsible to implement the corrective action? Administrator will be responsible for the completion of timely employee annual evaluations. When will the corrective action be implemented? 5/28/2015 What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? The tracking system will be reviewed each month by the Administrator or designee for the next month for upcoming evaluations and will schedule evaluation with the employee and the supervisor of the employee. The evaluations will be reviewed between the Administrator, Supervisor and employee before being placed in the employee file.</p>	05/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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 0143 Bldg. 00	<p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on clinical record review and interview, the agency failed to ensure communication was made to the physical therapist for a referral for 1 of 9 clinical records reviewed (#2) in which the patient was receiving more than one service.</p> <p>Findings:</p> <p>1) Clinical record #2 start of care date 10/3/2014, with a primary diagnosis of muscle weakness, indicated the nurse assessed the patient's fall risk and determined the patient was at risk for falls. An agency document titled Physical Therapy Referral evidenced the patient was referred for an evaluation by the physical therapist. The clinical record failed to evidence the physical therapist saw or evaluated the patient.</p> <p>2) In an interview with employee D, a physical therapist, on 5/21/2015 at 11:45 PM, the employee stated, "I was not notified of the need for a physical therapy referral and evaluation" for patient #2.</p>	G 0143	<p><b>G 143</b> What action will we take to correct the deficiency cited? With each admission, the admitting clinician will report to the DON within one business day the skills required to provide the patient with needed services. The DON or designee will contact auxiliary staff for initiation of service within same business day. Who is responsible to implement the corrective action? DON When will the corrective action be implemented? 5/28/2015 What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? All new admissions will be reviewed during the White Board Meeting/Case Conference which will be held weekly. Admissions completed since the previous White Board Meeting/Case Conference will be reviewed. See attached document White Board Meeting/Case Conference form.</p>	05/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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 0145  Bldg. 00	<p>484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure a written summary report for each patient was sent to the attending physician at least every 60 days for 2 of 8 records reviewed of patients receiving services for more than 60 days. (records #3 and 9)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical record #3, start of care 8/14/14 failed to evidence a 60 day summary was sent to the patient's physician for the certification period 2/12/15 through 4/12/15.</li> <li>2. Clinical record # 9, start of care 9/1/14 failed to evidence a 60 day summary was sent to the patient's physician for the certification period 2/28/14 through 4/28/15.</li> <li>3. An undated agency policy titled</li> </ol>	G 0145	<p><b>G145</b> What action will we take to correct the deficiency cited? The recerting clinician will place the 60 day summary in Box22 of the 485 immediately below the Discharge Plan on every recert. An Inservice for all recerting clinicians will be provided prior to clinician performing any upcoming recerts. Clinicians will sign an agreement stating they received this information. Who is responsible to implement the corrective action? DON When will the corrective action be implemented? 5/28/2015 What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? All recerts will be reviewed during the White Board Meeting/Case Conference which will be held weekly. Recerts completed since the previous White Board Meeting/Case Conference will be reviewed. See</p>	05/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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 0159 Bldg. 00	<p>Physician Summary states, "A summary report will be provided to the physician no less than every 60 days."</p> <p>4. In an interview with employee I, the agency's administrator, on 5/21/2015 at 12:25 PM, the administrator acknowledged that clinical records # 3 and 9 failed to include a 60 day summary report.</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the Plan of Care included physician orders for services for 1 of 10 clinical records reviewed.</p> <p>Findings:</p> <p>1) Clinical record #2, start of care date 10/3/2014, primary diagnosis muscle</p>	G 0159	<p>attached forms White Board Meeting/Case Conference and Recertagreement.</p> <p><b>G 159</b> What action will we take to correct the deficiency cited? With each admission, the admitting clinican will report tothe DON within one business day the skills required to provide the patient withneeded services. The DON or designee will contact axillary staff for initiationof service within same business day. The Plan of Care will reflect allservices/skills being provided to</p>	05/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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
	<p>weakness, included a plan of care established by the patient's physician for the certification period 10/3/2014 through 12/1/2014.</p> <p>A) Home Health aide visit notes dated 10/5/2014 evidenced that the patient reported having fallen on 10/4/2014.</p> <p>B) A transfer OASIS assessment dated 10/27/2014 evidenced that the patient was admitted to the hospital with injuries resulting from a fall.</p> <p>2) The comprehensive nursing assessment dated 10/3/2014 indicated the nurse assessed the patient's fall risk and determined the patient was at risk for falls.</p> <p>3) An agency document titled Physical Therapy Referral, dated 10/3/2014, evidenced the patient was referred to the physical therapist by the nurse for evaluation. The plan of care failed to include a physician order for physical therapy.</p> <p>4) An undated agency policy titled Plan of Care states, "The Plan of Care shall be completed in full to include: Type frequency and duration of all visits and services,...any safety measures to prevent</p>		<p>the patient</p> <p>Who is responsible to implement the corrective action? DON</p> <p>When will the corrective action be implemented? 5/28/2015</p> <p>What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? All new admissions will be reviewed during the White Board Meeting/Case Conference which will be held weekly. Admissions completed since the previous White Board Meeting/Case Conference will be reviewed. See attached form White Board Meeting/Case Conference</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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 0212 Bldg. 00	<p>injury...rehabilitation potential."</p> <p>484.36(b)(1) COMPETENCY EVALUATION &amp; IN-SERVICE TRAI</p> <p>The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section. Based on employee record review and interview, the home health agency failed to ensure all individuals furnishing home health aide services met competency evaluation requirements for 1 of 5 home health aide employee files reviewed. ( employee H)</p> <p>Findings:</p> <p>1) The record for employee H, a home health aide, date of hire 11/29/2013, date of first patient contact 12/3/2013, failed to evidence an initial written test and field competency check off evaluation for home health aides.</p> <p>2) In an interview with employee I, the agency's administrator, at 12:25 PM on 5/21/2013, the administrator stated, "[Employee H] works on an as needed basis and has not completed an initial written test and field competency evaluation for home health aides"</p>	G 0212	<p><b>G212</b></p> <p>What action will we take to correct the deficiency cited? With each new hire, the Administrator or designee will auditemployee file to ensure all proper documentation, including testing, is present, accurate and complete.</p> <p>Who is responsible to implement the corrective action? Administrator</p> <p>When will the corrective action be implemented? 5/28/2015</p> <p>What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? All new hires will be reviewed during the White Board Meeting/Case Conference which will be held weekly. Employees hired since the previous WhiteBoard Meeting/Case Conference will be reviewed. See attached form White Board Meeting/Case Conference</p>	05/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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 0321 Bldg. 00	<p>484.20(a) ENCODING OASIS DATA</p> <p>The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set.</p> <p>Based on ISDH and agency document review and agency policy review, the agency failed to ensure OASIS data was transmitted within 30 days of the M0900 date (date assessment completed) for 2 of 10 clinical records reviewed (#3 and 4) and for 20.7% of records submitted from 11/2014 through 4/2015.</p> <p>Findings:</p> <p>1 An ISDH report dated 5/8/2015, titled CASPER Report HHA Error Summary by Agency, evidenced 61 of 301 (20.7%) records were submitted greater than 30 days after the M0900 date.</p> <p>2. An agency document dated 3/17/2015, titled OASIS Final Validation Report, evidenced admission OASIS data submitted greater than 30 days after the M0900 date for clinical records #3 and 4.</p> <p>A. The M0090 date for the start of care assessment for clinical record 3 was 2/10/5 and the submission date was 3/17/15.</p>	G 0321	<p><b>G 321</b></p> <p>What action will we take to correct the deficiency cited? OASIS data will be transmitted each week by Administrator or designee. Incomplete OASIS that are not transmittable will be reported to DON. DON will contact clinician to instruct on need for completion within 24 hours.</p> <p>Who is responsible to implement the corrective action? Administrator</p> <p>When will the corrective action be implemented? 5/28/2015</p> <p>What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? OASIS Final Validation Report will be presented at WhiteBoard Meeting/Case Conference each week. During this meeting the Validation Report will cross referenced with Census, Admissions, Recerts, Hospitalizations, and Discharges. See attached form White Board Meeting/Case Conference</p>	05/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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
N 0000  Bldg. 00	<p>B. The M0090 date for the start of care assessment for clinical record 4 was 2/13/5 and the submission date was 3/17/15.</p> <p>3. An undated agency policy titled Encoding and Reporting OASIS Data states, "Encoding of all OASIS data must be completed (locked) to accurately complete the information necessary to send Medicare claims under the prospective payment system ... The agency will electronically report all OASIS data collected in accordance with federal regulations."</p> <p>This was a home health agency state relicensure survey.</p> <p>Survey Dates: 5/19/2015 through 5/21/2015</p> <p>Facility Number: IN012094</p> <p>Medicaid Provider ID: 200947690</p>	N 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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
N 0446 Bldg. 00	<p>Census Service Type: Skilled: 141 Home Health Aide Only: 34 Personal Services: 5 Total: 180</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>QR: JE 5/28/15</p> <p>410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on employee record and agency policy review and interview, the administrator failed to ensure staff evaluations were completed for 2014 for 2 of 8 employee records reviewed ( employees B and D).</p> <p>Findings:  1) Employee record B, a registered nurse, date of hire 7/12/ 2013, failed to evidence</p>	N 0446	<p><b>N 446</b></p> <p>What action will we take to correct the deficiency cited? The Administrator or designee will compile a tracking system to follow the annual employee evaluation due date. Who is responsible to implement the corrective action? Administrator will be responsible for the completion of timely employee annual evaluations. When will the corrective action be implemented? 5/28/2015</p>	05/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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
N 0456 Bldg. 00	<p>an annual evaluation of the employee's performance for 2014.</p> <p>2) Employee record D, a physical therapist, date of hire 11/28/09, failed to evidence an annual evaluation of the employee's performance for 2014.</p> <p>3) An undated agency policy titled, Performance Evaluations states, "A competency based performance evaluation will be conducted for all employees every 12 months of employment."</p> <p>4) In an interview with employee I, the agency's administrator, on 5/21/2015 at 12:25 PM, the administrator acknowledged that no performance evaluations had been completed for employees B and D for 2014.</p> <p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Based on agency document and policy</p>	N 0456	<p>What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? The tracking system will be reviewed each month by the Administrator or designee for the next month for upcoming evaluations and will schedule evaluation with the employee and the supervisor of the employee. The evaluations will be reviewed between the Administrator, Supervisor and employee before being placed in the employee file.</p> <p><b>N 456</b> What action will we take to</p>	06/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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
	<p>review and interview, the home health agency failed to implement, maintain and evaluate a quality assessment and performance improvement program using objective measures.</p> <p>Findings:</p> <p>1) An agency document, undated, titled Fall Prevention Program was presented by employee I, the agency's administrator on request for the agency's QAPI documentation. The document failed to evidence any documentation of implementation of fall prevention measures, collection of objective data regarding the effectiveness of the program, or minutes of QAPI meetings.</p> <p>2) In an interview with the administrator on May 19th at 1:10 PM, the administrator stated, "We have only recently implemented the program and have not collected any objective and measurable data to validate its effectiveness."</p> <p>3) An undated agency policy titled Performance Improvement" states, "The development of a performance improvement plan ... will reflect participation by all services and levels of staff ... data will be collected to allow the agency to monitor performance."</p>		<p>correct the deficiency cited? Agency'sDON and Administrator will implement processes from <a href="http://www.hhqi.com">www.hhqi.com</a> to help track and monitor patient incidents, patient outcomes and internal outcomes. All charts will be audited upon admission and prior to billing by DON. DON will be tracking Admit DX, hospitalization DX and assessing for verification that POC interventions are addressed and documented, that communication between skills, including aides, nurses and therapists, are documented and findings requiring physician notification have been reported and documented. Also, notes and timesheets will be audited by DON and Director of Operations to ensure that service hours/days authorized are being met and communications between disciplines are taking place. Should discrepancy in hours used/authorized, communication between disciplines or POC and actual care/interventions be identified, staff will be educated by DON and/or Administrator on issue, if three occurrences are found within a month then in-depth in-servicing followed by testing to ensure understanding of content of in-service will be conducted with entire agency by DON and/or Administrator, at that point it will become a QA/QI focus and the <a href="http://www.hhqi.com">www.hhqi.com</a> tracking and monitoring system will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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
N 0472 Bldg. 00	<p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on agency document and policy review and interview, the home health agency failed to implement, maintain and evaluate a quality assessment and performance improvement program using objective measures.</p> <p>Findings:</p> <p>1) An agency document, undated, titled Fall Prevention Program was presented by employee I, the agency's administrator</p>	N 0472	<p>implemented by Administrator and will be followed for 6 months to ensure compliance with corrective actions. These and all occurrences will be addressed and monitored on a weekly basis by management and office during white board meeting (please see attached monitoring tool labeled "unwanted occurrences").</p> <p><b>N 472</b> What action will we take to correct the deficiency cited? Agency's DON and Administrator will implement processes from <a href="http://www.hhqi.com">www.hhqi.com</a> to help track and monitor patient incidents, patient outcomes and internal outcomes. All charts will be audited upon admission and prior to billing by DON. DON will be tracking Admit DX, hospitalization DX and assessing for verification that POC interventions are addressed and documented, that communication between skills,</p>	06/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/21/2015
NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394		
(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	
N 0484 Bldg. 00	<p>on request for the agency's QAPI documentation. The document failed to evidence any documentation of implementation of fall prevention measures, collection of objective data regarding the effectiveness of the program, or minutes of QAPI meetings.</p> <p>2) In an interview with the administrator on May 19th at 1:10 PM, the administrator stated, "We have only recently implemented the program and have not collected any objective and measurable data to validate its effectiveness."</p> <p>3) An undated agency policy titled "Performance Improvement" states, "The development of a performance improvement plan ... will reflect participation by all services and levels of staff ... data will be collected to allow the agency to monitor performance."</p> <p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing</p>		<p>including aides, nurses and therapists, are documented and findings requiring physician notification have been reported and documented. Also, notes and timesheets will be audited by DON and Director of Operations to ensure that service hours/days authorized are being met and communications between disciplines are taking place. Should discrepancy in hours used/authorized, communication between disciplines or POC and actual care/interventions be identified, staff will be educated by DON and/or Administrator on issue, if three occurrences are found within a month then in-depth in-servicing followed by testing to ensure understanding of content of in-service will be conducted with entire agency by DON and/or Administrator, at that point it will become a QA/QI focus and the www.hhqi.com tracking and monitoring system will be implemented by Administrator and will be followed for 6 months to ensure compliance with corrective actions. These and all occurrences will be addressed and monitored on a weekly basis by management and office during white board meeting (please see attached monitoring tool labeled "unwanted occurrences").</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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
	<p>services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on clinical record review and interview, the agency failed to ensure communication was made to the physical therapist for a referral for 1 of 9 clinical records reviewed (#2) in which the patient was receiving more than one service.</p> <p>Findings:</p> <p>1) Clinical record #2 start of care date 10/3/2014, with a primary diagnosis of muscle weakness, indicated the nurse assessed the patient's fall risk and determined the patient was at risk for falls. An agency document titled Physical Therapy Referral evidenced the patient was referred for an evaluation by the physical therapist. The clinical record failed to evidence the physical therapist saw or evaluated the patient.</p> <p>2) In an interview with employee D, a physical therapist, on 5/21/2015 at 11:45 PM, the employee stated, "I was not notified of the need for a physical therapy referral and evaluation" for patient #2.</p>	N 0484	<p><b>N484</b></p> <p>What action will we take to correct the deficiency cited? With each admission, the admitting nurse will report to the DON within one business day the skills required to provide the patient with needed services. The DON or designee will contact axillary staff for initiation of service within same business day. Staff will be instructed on requirement to advise DON of patient falls, witnessed or reported, within same business day of acquiring knowledge of the fall. DON will track and record fall incident facts. Who is responsible to implement the corrective action? DON When will the corrective action be implemented? 5/28/2015 What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? All new admissions will be reviewed during the White Board Meeting/Case Conference which will be held weekly. Admissions completed since the previous White Board Meeting/Case</p>	05/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care 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. (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. Based on clinical record and policy review and interview, the agency failed to	N 0524	Conference will be reviewed. All fall reports will bereviewed during the White Board Meeting/Case Conference which will be heldweekly. Fall reports completed since theprevious White Board Meeting/Case Conference will be reviewed. See attacheddocument White Board Meeting/Case Conference and Incident Report form.  N524 What action will we take to correct	05/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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
	<p>ensure the Plan of Care included physician orders for services for 1 of 10 clinical records reviewed.</p> <p>Findings:</p> <p>1) Clinical record #2, start of care date 10/3/2014, primary diagnosis muscle weakness, included a plan of care established by the patient's physician for the certification period 10/3/2014 through 12/1/2014.</p> <p>A) Home Health aide visit notes dated 10/5/2014 evidenced that the patient reported having fallen on 10/4/2014.</p> <p>B) A transfer OASIS assessment dated 10/27/2014 evidenced that the patient was admitted to the hospital with injuries resulting from a fall.</p> <p>2) The comprehensive nursing assessment dated 10/3/2014 indicated the nurse assessed the patient's fall risk and determined the patient was at risk for falls.</p> <p>3) An agency document titled Physical Therapy Referral, dated 10/3/2014, evidenced the patient was referred to the physical therapist by the nurse for evaluation. The plan of care failed to</p>		<p>the deficiency cited?</p> <p>With each admission, the admitting nurse will report to the DON within one business day the skills required to provide the patient with needed services. The DON or designee will contact axillary staff for initiation of service within same business day. Staff will be instructed on requirement to advise DON of patient falls, witnessed or reported, within same business day of acquiring knowledge of the fall. DON will track and record fall incident facts.</p> <p>Who is responsible to implement the corrective action? DON</p> <p>When will the corrective action be implemented? 5/28/2015</p> <p>What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? All new admissions will be reviewed during the White Board Meeting/Case Conference which will be held weekly. Admissions completed since the previous White Board Meeting/Case Conference will be reviewed. All fall reports will be reviewed during the White Board Meeting/Case Conference which will be held weekly. Fall reports completed since the previous White Board Meeting/Case Conference will be reviewed. See attached document White Board Meeting/Case</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/21/2015	
NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394			
(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			
N 0529 Bldg. 00	<p>include a physician order for physical therapy.</p> <p>4) An undated agency policy titled Plan of Care states, "The Plan of Care shall be completed in full to include: Type frequency and duration of all visits and services, ... any safety measures to prevent injury ... rehabilitation potential."</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on clinical record and policy review and interview, the agency failed to ensure a written summary report for each patient was sent to the attending physician at least every 2 months for 2 of 8 records reviewed of patients receiving services for more than 2 months. (records #3 and 9)</p> <p>Findings:</p> <p>1. Clinical record #3, start of care 8/14/14 failed to evidence a summary</p>	N 0529	<p>Conference form and Incident Report.</p> <p><b>N529</b> What action will we take to correct the deficiency cited? The recerting clinician will place the 60 day summary in Box22 of the 485 immediately below the Discharge Plan on every recert. An Inservice for all recerting clinicians will be provided prior to clinician performing any upcoming recerts. Clinicians will sign an agreement stating they received this information. Who is responsible to implement the corrective action? DON When will the corrective action be</p>	05/28/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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
	<p>report was sent to the patient's physician for the certification period 2/12/15 through 4/12/15.</p> <p>2. Clinical record # 9, start of care 9/1/14 failed to evidence a summary report was sent to the patient's physician for the certification period 2/28/14 through 4/28/15.</p> <p>3. An undated agency policy titled Physician Summary states, "A summary report will be provided to the physician no less than every 60 days."</p> <p>4. In an interview with employee I, the agency's administrator, on 5/21/2015 at 12:25 PM, the administrator acknowledged that clinical records # 3 and 9 failed to include a 60 day summary report.</p>		<p>implemented? 5/28/2015</p> <p>What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? All recerts will be reviewed during the White Board Meeting/Case Conference which will be held weekly. Recerts completed since the previous White Board Meeting/Case Conference will be reviewed. See attached forms White Board Meeting/Case Conference and Recert agreement.</p> <p>What action will we take to correct the deficiency cited? The recerting clinician will place the 60 day summary in Box 22 of the 485 immediately below the Discharge Plan on every recert. An Inservice for all recerting clinicians will be provided prior to clinician performing any upcoming recerts. Clinicians will sign an agreement stating they received this information.</p> <p>Who is responsible to implement the corrective action? DON</p> <p>When will the corrective action be implemented? 5/28/2015</p> <p>What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? All recerts will be reviewed during the White Board Meeting/Case Conference which will be held</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394
--	---

(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
N 0596  Bldg. 00	<p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on employee record review and interview, the home health agency failed to ensure all individuals furnishing home health aide services met competency evaluation requirements for 1 of 5 home health aide employee files reviewed. ( employee H)</p> <p>Findings:  1) The record for employee H, a home health aide, date of hire 11/29/2013, date of first patient contact 12/3/2013, failed to evidence an initial written test and field competency check off evaluation for home health aides.</p>	N 0596	<p>weekly. Recerts completed since the previous WhiteBoard Meeting/Case Conference will be reviewed. See attached forms White Board Meeting/Case Conference and Recertagreement.</p> <p><b>N596</b> What action will we take to correct the deficiency cited? With each new hire, the Administrator or designee will auditemployee file to ensure all proper documentation, including testing, is present, accurate and complete. Who is responsible to implement the corrective action? Administrator When will the corrective action be implemented? 5/28/2015 What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? All new hires will be reviewed during</p>	05/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157610	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  05/21/2015
NAME OF PROVIDER OR SUPPLIER  HOME HEALTH ANGELS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 117 N MAIN ST PO BOX 283 WINCHESTER, IN 47394		
(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	
	2) In an interview with employee I, the agency's administrator, at 12:25 PM on 5/21/2013, the administrator stated, "[Employee H] works on an as needed basis and has not completed an initial written test and field competency evaluation for home health aides"		the White Board Meeting/Case Conference which will be held weekly. Employees hired since the previous WhiteBoard Meeting/Case Conference will be reviewed. See attached form White Board Meeting/Case Conference		