This was a home health agency federal recertification survey. This was a partial extended survey.

Survey Dates: 5/19/2015 through 5/21/2015

Facility Number: IN012094

Medicaid Provider ID: 200947690

Census Service Type:
- Skilled: 141
- Home Health Aide Only: 34
- Personal Services: 5
- Total: 180

Sample:
- RR w/HV: 5
- RR w/o HV: 5
- Total: 10

QR: JE 5/28/15

The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures
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).

Findings:

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.

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.

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."

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.

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.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 157610

MULTIPLE CONSTRUCTION

A. BUILDING 00
B. WING

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

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G 0143
Bldg. 00

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.

Findings:

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.

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.

What action will we take to correct the deficiency cited?

G 0143

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 the 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.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 157610

MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

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

ID PREFIX TAG

G 0145 Bldg. 00

SUMMARY STATEMENT OF DEFICIENCIES
(GR 0145)
COORDINATION OF PATIENT SERVICES
A written summary report for each patient is
sent to the attending physician at least every
60 days.

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)

Findings:

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.

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.

3. An undated agency policy titled

ID PREFIX TAG

G 0145

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

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
**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

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**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
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<tbody>
<tr>
<td>G 0159</td>
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<td>attached forms White Board Meeting/Case Conference and Recertagreement.</td>
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**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.**

**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.

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.

**Findings:**

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.

A) Home Health aide visit notes dated 10/5/2014 evidenced that the patient reported having fallen on 10/4/2014.

B) A transfer OASIS assessment dated 10/27/2014 evidenced that the patient was admitted to the hospital with injuries resulting from a fall.

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.

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.

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

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 form White Board Meeting/Case Conference
### Summary of Deficiencies

The Home Health Agency (HHA) 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)

**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.
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."

### Corrective Action Plan

**What action will we take to correct the deficiency cited?**

With each new hire, the Administrator or designee will audit employee 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 the White Board Meeting/Case Conference which will be held weekly. Employees hired since the previous White Board Meeting/Case Conference will be reviewed. See attached form White Board Meeting/Case Conference.
ENCODING OASIS DATA
The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set. 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.

Findings:

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.

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.

   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.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**  
**IDENTIFICATION NUMBER:** MULTIPLE CONSTRUCTION  
**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  

<table>
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<th>(X4) ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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| N 0000 | B. The M0090 date for the start of care assessment for clinical record 4 was 2/13/15 and the submission date was 3/17/15.  
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." | N 0000 | Bldg. 00 | | | |

This was a home health agency state relicensure survey.  

Survey Dates: 5/19/2015 through 5/21/2015  
Facility Number: IN012094  
Medicaid Provider ID: 200947690
### Summary Statement of Deficiencies

#### Prefix: N 0446

**ID**
- **Bldg.** 00

**Tag**
- Census Service Type:
  - Skilled: 141
  - Home Health Aide Only: 34
  - Personal Services: 5
  - Total: 180

#### Sample:
- RR w/HV: 5
- RR w/o HV: 5
- Total: 10

**QR: JE 5/28/15**

**Rule 12 410 IAC 17-12-1(c)(3)**

- Home health agency administration/management
- Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following:
  1. 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).

#### Findings:

1) Employee record B, a registered nurse, date of hire 7/12/2013, failed to evidence
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
IDENTIFICATION NUMBER: 157610

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
06/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
IDENTIFICATION NUMBER: 157610

HOME HEALTH ANGELS LLC
117 N MAIN ST PO BOX 283
WINCHESTER, IN 47394

N 0456
Bldg. 00
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

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?
The tracking system will 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.

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

What action will we take to 06/18/2015

GRBN11 012094 If continuation sheet Page 11 of 21
<table>
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</tr>
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**review and interview, the home health agency failed to implement, maintain and evaluate a quality assessment and performance improvement program using objective measures.**

**Findings:**

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.

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."

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."

correct the deficiency cited? Agency's DON and Administrator will implement processes from [www.hhqi.com](http://www.hhqi.com) to help track and monitor patientincidents, patient outcomes and internal outcomes. All charts will be audited uponadmission and prior to billing by DON. DON will be tracking Admit DX,hospitalization DX and assessing for verification that POC interventions areaddressed and documented, that communication between skills, including aides,nurses and therapists, are documented and findings requiring physiciannotification have been reported and documented. Also, notes and timesheets willbe audited by DON and Director of Operations to ensure that service hours/daysauthorized are being met and communications between disciplines are takingplace. Shoulddiscrepancy in hours used/authorized, communication between disciplines or POCand actual care/interventions be identified, staff will be educated by DONand/or Administrator on issue, if three occurrences are found within a monththen in-depth in-servicing followed by testing to ensure understanding ofcontent of in-service will be conducted with entire agency by DON and/orAdministrator , at that point it will become a QA/QI focus and the [www.hhqi.com](http://www.hhqi.com)tracking and monitoring system will be
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 157610

MULTIPLE CONSTRUCTION
A. BUILDING 00
B. WING

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

PREFIX TAG ID

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

N 0472
Bldg. 00

410 IAC 17-12-2(a) QA 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.

Findings:

1) An agency document, undated, titled Fall Prevention Program was presented by employee I, the agency's administrator

What action will we take to correct the deficiency cited?

Agency's DON and Administrator will implement processes from www.hhqi.com 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, 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").

06/18/2015

N 472

0 12094

Page 13 of 21
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.

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."

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."

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").
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.

Findings:

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.

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.

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<td>N484</td>
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<td>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 auxiliary 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</td>
<td>05/28/2015</td>
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</table>

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.

Findings:

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.

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.
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<td>410 IAC 17-13-1(a)(1)</td>
<td>Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</td>
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<tr>
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<td>(A) Be developed in consultation with the home health agency staff.</td>
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<td>(B) Include all services to be provided if a skilled service is being provided.</td>
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<td>(C) Cover all pertinent diagnoses.</td>
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<td>(D) Include the following:</td>
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<td>(i) Mental status.</td>
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<td>(ii) Types of services and equipment required.</td>
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<td>(iii) Frequency and duration of visits.</td>
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<td>(iv) Prognosis.</td>
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<td>(v) Rehabilitation potential.</td>
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<td>(viii) Nutritional requirements.</td>
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<td>(ix) Medications and treatments.</td>
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<td>(x) Any safety measures to protect against injury.</td>
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<td>(xi) Instructions for timely discharge or referral.</td>
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<td>(xii) Therapy modalities specifying length of treatment.</td>
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<td>(xiii) Any other appropriate items.</td>
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<td>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 Conference and Incident Report form.</td>
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<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>N524</td>
<td>05/28/2015</td>
<td>N 0524</td>
<td>What action will we take to correct</td>
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ensure the Plan of Care included physician orders for services for 1 of 10 clinical records reviewed.

Findings:

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.

   A) Home Health aide visit notes dated 10/5/2014 evidenced that the patient reported having fallen on 10/4/2014.

   B) A transfer OASIS assessment dated 10/27/2014 evidenced that the patient was admitted to the hospital with injuries resulting from a fall.

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.

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

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 auxiliary 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 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
Home Health Angels LLC

117 N MAIN ST PO BOX 283
WINCHESTER, IN 47394

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 157610

MULTIPLE CONSTRUCTION
A. BUILDING 00 B. WING

DATE SURVEY COMPLETED: 05/21/2015

STATEMENT OF DEFICIENCIES

Include a physician order for physical therapy.

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."

Conference form and Incident Report.

Findings:

1. Clinical record #3, start of care 8/14/14 failed to evidence a summary

ID: N0529
PREFIX: Bldg. 00
TAG: 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)

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 completed?

05/28/2015
### Statement of Deficiencies and Plan of Correction

**Identification Number:** 157610  
**Date Survey Completed:** 05/21/2015

**Provider/Supplier/CLIA:** MULTIPLE CONSTRUCTION  
**Building:** 00  
**Wing:**

**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

### Summary Statement of Deficiencies

1. A summary report was sent to the patient's physician for the certification period 2/12/15 through 4/12/15.

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.

3. An undated agency policy titled Physician Summary states, "A summary report will be provided to the physician no less than every 60 days."

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.

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**Provider's Plan of Correction**

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 attached forms White Board Meeting/Case Conference and Recert Agreement.

- 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.

- 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.
### Statement of Deficiencies and Plan of Correction

Name of Provider or Supplier: Home Health Angels LLC

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<tr>
<th>ID</th>
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<th>Summary Statement of Deficiencies</th>
<th>ID</th>
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<th>Tag</th>
<th>Provider's Plan of Correction</th>
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<tbody>
<tr>
<td>N 0596</td>
<td>Bldg. 00</td>
<td>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) 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.</td>
<td>N 0596</td>
<td>N 0596</td>
<td>Weekly. Recerts completed since the previous WhiteBoard Meeting/Case Conference will be reviewed. See attached forms White Board Meeting/Case Conference and Recertagreement.</td>
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What action will we take to correct the deficiency cited?

With each new hire, the Administrator or designee will audit employee 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 weekly.
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"